The Healing Sanctuary

AN AFFILIATE OF MOUNTAIN VIEW HOSPITAL

HIPAA AUTHORIZATION
FOR
USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability And Accountability Act of 1996 {HIPAA) Privacy Standards.

Patient Name:_____ Date of Birth:_____

I. My Authorization

I authorize **The Healing Sanctuary** to use or disclose the health information indicated below with the following

Individual(s): _____Date of Birth:_____Relationship: _____

Individual(s): _____Date of Birth:_____Relationship: _____

Individual(s): _____Date of Birth:_____Relationship: _____

Health Information to be used or disclosed: (Check one)

- ☐ All of patients health information
- ☐ Health information covering dates from _____ to _____
- ☐ Health information relating to following treatment or condition

  _____
- ☐ Other: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create healthy information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I understand that I can receive a copy of this authorization after I have signed it at any time I request a copy.

Signature of Patient:_____ Date:_____

Patient Sticker
Last _____
First _____
DOB _____
FIN _____