Instructions for Completing our HIPAA Privacy Authorization Form

If you would like someone other than yourself to have access to your medical records and information, and to allow us to release or disclose that information, you must authorize this. In this case we prefer it be in writing.

Since **a Durable Power of Attorney for Health Care** is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information while you remain competent. If you want someone other than yourself to have access to that information now, while you remain competent, you need to complete and sign our HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

This is a **General Authorization** form and should be filled out by the patient or their personal representative requesting the release, rather than the entity or person receiving or releasing the information. However, if you need help filling out this form, we are happy to provide assistance.

In Section 1 insert the **name** of health care provider (hospital, physician, practice, etc.) you are authorizing to release your information (most often this will be our practice name), and the name of person or entity authorized to receive the information. You may use a single form to designate multiple persons or entities who are authorized to receive your information.

In Section 2 indicate **time period** of information covered by the authorization.

In Section 3 indicate **what information** is allowed to be released.

In Section 4 indicate how long the authorization is to remain **effective**, for example until a certain date or until your death. You have the power to revoke, the authorization in writing at any time by notifying the entity or person you have authorized to release information.

The form needs to be **signed by the patient** or by the personal representative of the patient, such as a parent, if the patient is a minor.

This General Authorization form may not be used for:

- Authorizations to use PHI for Marketing
- Specific authorizations for use of PHI other than allowed by law
- Conditional authorizations relating to research or insurance benefits

Patient initials _____

HIPAA Privacy Authorization Form

Authorization for Disclosure or Release of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I, the undersigned, hereby authorize my medical records to be released

□ To □ From	**Name:** The Healing Sanctuary _____ **Address:** 187 E. 13th Street, Idaho Falls, ID 83404 _____ **Phone:** (208) 497-0500 **Fax:** (208) 497-0198
□ To □ From	**Name:** _____ _____ **Address:** _____ _____ **Phone:** _____ **Fax:** _____

2. I hereby authorize release of information covering the **period of health care** from (check one box):

□ _____ to _____ **OR** □ all past, present and future periods

3. **Information to be released** (check only one box, whichever is most appropriate):

Patient full name: _____ Birthdate: _____

3a. □ I hereby authorize release of my **complete health record** for the dates indicated above including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol / drug abuse, if any.
3b. □ I hereby authorize release of my **x-rays or other imaging only**
3c. □ I hereby authorize release of only _____
3d. □ I hereby authorize release of my complete health record **with exception** of the following:
check any boxes that apply

- □ Mental health records
- □ Communicable diseases including HIV and AIDS
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

4. This protected health information **may be used** by person(s) or entities I authorize to receive it, for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization **shall be in force** until this date or event: _____,
at which time it expires.

6. I understand I have the **right to revoke** this authorization in writing at any time, but some actions already taken based on my original authorization may not be reversible.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand information used or disclosed under this authorization may be further disclosed by certain recipients, and in some cases may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship (if not Patient)