

# HIPAA Authorization Form

## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable. (Page 1 of 4)

### Section 1 – Patient/Plan Member Information

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Reference N°: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_

### Section 2 - Individual/Organization Authorized by Signatory to Disclose PHI

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_

### Section 3 - Individual/Organization Authorized by Signatory to Receive PHI

Name: Michael Clark MD, PhD  
Relationship to Patient/Plan Member: Physician  
Telephone N°: Voice: 206-736-1316 Fax: 206-803-1207  
Address: 200 1st Ave W, Suite 400  
City/State/ZIP: Seattle WA 98125

### Section 4 - Authorization Expiration Event or Date

Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing.

Expiration Event: N/A Expiration Date: 6mo from date of signing

# HIPAA Authorization Form

## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable. (Page 2 of 4)

### Section 5 – Health Information to be Disclosed - General

I authorize the following Protected Health Information to be disclosed:

Medical Records                       Dental Records                       Other Non-Specific

If Other Non-Specific, provide details: \_\_\_\_\_

### Section 6 – Health Information to be Disclosed – Specific

I authorize the following Protected Health Information to be disclosed:

Communicable Disease    Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Reproductive Health      Signature: \_\_\_\_\_    Date: \_\_\_\_\_

HIV Test Results          Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Mental Health Records \*    Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Substance Use Disorder    Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Other                              Signature: \_\_\_\_\_    Date: \_\_\_\_\_

If "Other", provide details: \_\_\_\_\_

**\* Requests for psychotherapy notes require a separate HIPAA Authorization Form and may not be combined with any other request.**

Psychotherapy Notes      Signature: \_\_\_\_\_    Date: \_\_\_\_\_

### Section 7 - Purpose of the Release or Use of Health Information

Healthcare     Research     Marketing     Sale     Legal

Other (please specify): \_\_\_\_\_

Note: The sale of PHI authorized by this HIPAA Authorization Form will result in remuneration to the party specified in Section 2.

# HIPAA Authorization Form

## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable. (Page 3 of 4)

### Section 8 - Authorization Information

I understand the following:

1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4.
2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information by the party specified in Section 2 from the date of receipt. I understand a delay may exist if the party specified in Section 2 is not the covered entity authorized to disclose Protected Health Information to the party specified in Section 2. I also understand that a written revocation is not effective with respect to actions the covered entity or party specified in Section 2 took in reliance on a valid Authorization, or where the Authorization was obtained as a condition of obtaining insurance coverage.
3. I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.
4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations.
5. I have a right to receive a copy of this HIPAA Authorization Form.
- 6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

### Section 9 - Additional Conditions that Apply to this HIPAA Authorization Form

---

---

---

# HIPAA Authorization Form

## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable. (Page 4 of 4)

### **Section 10 - Signature by or on Behalf of Patient/Plan Member**

Name of Patient/Plan Member (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of signatory if not patient/plan member: \_\_\_\_\_

Authority to sign on behalf of patient/plan member: \_\_\_\_\_

Name of translator (if applicable): \_\_\_\_\_

Signature of translator (if applicable) \_\_\_\_\_