HIPAA AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
as required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

I, _____ date of birth _____, give permission to the following medical providers and facilities:

_____ _____
_____ _____
West Seattle Wellness _____

- ❑ to discuss the following protected health information with any other provider listed above, and/or
- ❑ to use the following protected health information, and/or
- ❑ to disclose the following protected health information with any other provider listed above.

Protected Health Information Authorized:

Medical Records
including Health History, and Prescriptions
Personal Information such as details disclosed on Intake Forms
Treatment Records
Diagnostic Records

with the exception of Protected Health Information Requiring specific Authorization:

- ❑ I authorize Mental health records
- ❑ I authorize Communicable diseases (including HIV and AIDS) records
- ❑ I authorize Alcohol/drug abuse treatment records

This protected health information is being used or disclosed for the purposes of medical treatment, consultation, medical collaboration, continuity of care, or other purposes as I may direct. An electronic copy shall be as valid as the original or a photocopy.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation will not apply to actions taken prior to the date of the receipt of the revocation notice.

I had read and understand this authorization. I release above named parties from legal responsibility that may arise from this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative