HIPAA Privacy Authorization Form

Authorized for Use or Disclosure of Protected Health Information for Celina Medical Clinic

(Required by the Health Insurance Portability and Accountability Acct – 45 CFR Parts 160 & 164)

Please print all information, then sign and date form at bottom.

Type of Authorization: Release of limited protected health information to a designated person.

Patient Name (please print) _____ Patient Date of Birth_____

Purpose of request – I authorize Celina Medical Clinic to utilize the protected health information, about me, from the entity, person or persons identified below:

Release to:	Released from:
Celina Medical Clinic	_____
701 N. Preston Rd, Ste 200	_____
Celina, TX 75009	_____
972-382-3939 (work) 972-382-2211 (fax)	_____

Description of information to be disclosed:

☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

☐ I hereby **authorize the release of my complete health record with the exception of the following information:**

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

Purpose of disclosure – This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Please list the reason for this request or check patient request: **_____ patient request**

_____

Expiration or termination of authorization – This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue to authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. Please list an earlier expiration if less than one year: _____ I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Celina Medical Clinic.

_____ _____

Patient signature Date