Form 4-5, HIPPA Authorization

HIPAA Authorization

1. **I_____ hereby authorize any Health Care Provider to disclose any or all of my Individually Identifiable Health Information upon request to the following Authorized Persons:**

   _____ _____ _____

2. **The above authorization shall include answering the questions of any of my Authorized Persons and discussing the disclosed information, even if I am fully competent to ask questions and discuss the information at the time.**

3. **Health Care Provider means any health care provider or covered entity as defined in the Health Insurance Portability and Accountable Act (HIPAA) or its associated regulations. Health Care Provider includes any person or entity that is prevented by HIPAA from disclosing information to my Authorized Persons.**

4. **Individually Identifiable Health Information means any individually identifiable health information of protected health information as defined in HIPAA or its associated regulations.**

5. **This Authorization shall expire four years after I die, unless I have revoked it in writing before then. No revocation shall take effect until it is actually received by the Health Care provider that is being asked to disclose information, and no revocation shall apply to the extent that a health Care Provider has taken action in reliance upon this Authorization.**

6. **I understand that information which is disclosed pursuant to this Authorization may be re-disclosed by my Authorized Person, and that HIPAA will no longer protect such information after disclosure to my Authorized Persons. No Health Care Provider shall require any of my Authorized Persons to indemnify or release the Health Care Provider as a prerequisite to complying with this Authorization. No Health Care Provider may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.**

7. **Any of my Authorized Persons may sign any documents that he or she deems appropriate to obtain my Individually Identifiable Health Information. Any of my Authorized Persons shall have the right to file suit or take any other legal action to obtain Individually Identifiable Health Information from any Health Care Provider that refuses to accept and act upon the Authorization.**

8. **I hereby release any Health Care Provider from any liability that it incurs as a result of acting in reliance upon this Authorization (or upon a photocopy, scan, or facsimile of it). No Health Care Provider shall be responsible for the actions of my Authorized Persons.**

   Signed this ____ day of _____, 20____

   _____

   Patient Signature