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COMPTON INTERNAL MEDICINE CARE

INTERVENTIONAL PAIN INSTITUTE

COMPTON CHIROPRACTIC CARE

# HIPAA Privacy Authorization Form

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

1. Authorization

   I _____authorize the above office to Obtain/Release medical information via mail, facsimile, or other appropriate secure means to:

   □ Other healthcare providers involved in my care or to be involved
   □ My Attorney
   □ Family/Friend: _____, _____, _____,
   □ Other: _____

2. Consent to view prescription history (PMP)
   Consent to view imaging, notes, test results from outside facilities
   Consent to communicate with patient via secure email or text for reminders and information

3. **Effective Period**: This authorization for release of information covers the period of healthcare from All past, present and future periods unless otherwise stated here: _____

4. Extent of Authorization

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

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

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

5. 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.
6. I understand that I have the right to revoke this authorization, **in writing**, at any time. 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 consent a claim.
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 that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Name _____ Patient Signature _____ Date _____