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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 Union Square Medical Associates to use and or disclose the protected health information upon my request by phone, in-person or email to:

_____

_____

_____
(Individual seeking the information and or individual's advocate/s)

2. Effective Period
This authorization for release of information covers all past, present, and future periods.

3. This medical information can only be given to me or any other person I legally authorize to share my information with.

4. 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 contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. 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.

7. I understand that the office has 48 business hours to send my medical records as requested

8. The type of information shared with me will only be at my request and or if I have a phone appointment.

Name of patient: _____ DOB:_____

Signature of patient: _____

Witness Signature _____ Date:_____