BHC–BEHAVIORAL
HEALTH CONSULTANTS, INC

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME: _____ **DATE OF BIRTH:** ____ / ____ / ____

1. Authorization

I authorize _____ (medical provider) to use and disclose the protected health information described below to _____ (individual/entity seeking the information) for the following purposes: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Employment ☐ Education ☐ Personal Use ☐ Other: _____

Individual's/Entity's Telephone # _____ | **Individual's/Entity's Fax #** _____

Individual's/Entity's Mailing Address _____

2. Effective Period *(check one)*

This authorization for release of information covers the period of healthcare from:

☐ a. ____ / ____ / ____ to ____ / ____ / ____ *OR* ☐ b. all past, present, and future periods.

3. Extent of Authorization *(check one)*

☐ a. I authorize the release of my complete health record, which may include information relating to the diagnosis and treatment of drugs, alcohol, and psychiatric disorders. *OR*

☐ b. I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. Effective Time Period

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; 180 days following the date of the signature, or the following specific date (optional): ____ / ____ / ____

5. This medical information may be used by the person I authorized to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether or not I sign this authorization.

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 who 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.

7. 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.

_____ _____

Printed name of patient or personal representative | If representative, specify above the relationship to the patient

_____ ____ / ____ / ____

Signature of patient or personal representative | Date of signature