

# **HIPAA AUTHORIZATION**

## **STATEMENT OF INTENT**

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

## **AUTHORIZATION**

I, \_\_\_\_\_, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

to the following authorized persons:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

### **TERMINATION**

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

### **RE-DISCLOSURE**

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

### **INSTRUCTIONS TO MY AUTHORIZED PERSONS**

My authorized persons shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected medical information.

**VALID DOCUMENT**

A copy or facsimile of this original authorization shall be accepted as though it were an original document.

**WAIVER AND RELEASE**

I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Signed on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

THE STATE OF TEXAS  
COUNTY OF \_\_\_\_\_

This instrument was acknowledged before me on the \_\_\_\_ day of \_\_\_\_\_, 20 \_\_,  
by \_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Texas