HIPAA Privacy Authorization Form

1. Authorization

I authorize The Alternative Clinic to disclose my protected health information described below to

_____ (individual seeking the information).

2. Effective Period

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

a. □ _____ to _____

b. □ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health & treatment record

b. □ I authorize the disclosure of health record pertaining to the following condition, claim or situation only:

_____

4. This medical information may be used by the person I authorize to receive information for treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization, has obtained as a condition of obtaining insurance coverage and the insurerhas 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.

Signature

_____

Date

_____