AMERICA'S FAMILY DOCTORS®
Walk-ins Welcome, We Care 7 Days a Week!

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AFD Clinics 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)

Patient Name: _____ **Date Of Birth**: _____

1. Authorization

I hear by request access to the protected health information in my health record; maintained or created by the provider named below, to recipient named below. **Reason for authorization**: _____.

Records From	**Records To**
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

2. Expiration Notice

This authorization shall expire **90 days** from the date signed below, and covers only treatment prior to that date.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

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

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

4. 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.

5. 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.

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

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 of patient or personal representative Date

_____ _____
Printed name of patient Personal representative and his or her relationship to patient