MADISON WOMEN'S CLINIC
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Phone 208-356-6185 | Fax 208-356-0378
WWW.MADISONWOMENSCLINIC.COM

# HIPAA Privacy Release Authorization

## Authorization for Disclosure or Release of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I, the undersigned, authorize disclosure of the protected health information described below to **Madison Women's Clinic** by:
   ENTITY: _____
   ADDRESS: _____
   PH: _____ FAX: _____

2. Covering the **period of health care** from: _____ to _____ **OR**, circle: **ALL**

3. **Information to be released:**

   Patient full name: _____ Birthdate: _____

   Address: _____

   **3a.** □ **Complete health record** for the dates indicated above
   - □ **INCLUDE** records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol / drug abuse, if any.
   - □ **Specifically, DO NOT INCLUDE**: (check all boxes that apply)
     - □ Mental health records
     - □ Communicable diseases including HIV and AIDS
     - □ Alcohol/drug abuse treatment
     - □ Other (please specify): _____

   **3b.** □ **This medical imaging only** _____
   **3c.** □ **This information only** _____

4. This information **may be used** by person(s) or entities I authorize to receive it, for any purposes as I may direct.

5. This authorization **shall be in force** until this date or event: _____, at which time it expires.

6. I have the **right to revoke** this authorization in writing at any time, but I understand some actions already taken based on my original authorization may not be reversible.

7. I understand that treatment, payment, enrollment in a health plan or eligibility for benefits **will not be conditioned** on whether I provide a requested authorization for use or disclosure except if my treatment is related to research, or to health care services provided to me for the purpose of creating protected health information for a third party.

8. I understand that information used or disclosed under this authorization may be **further disclosed** by certain recipients, and in some cases may no longer be protected by federal or state law.

**THIS FORM IS NOT VALID WITHOUT A SIGNATURE ON THE REVERSE**

## Authorizing Signature

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship (if not Patient)

MWC office use only:
PHI: MAILED FAXED HANDCARRIED on _____ by _____

## Instructions for Completing our HIPAA Privacy Release Authorization Form

If you would like someone other than yourself to have access to your medical records and information, and to allow us to release or disclose that information, you must authorize this. In this case we prefer it be in writing.

Since a **Durable Power of Attorney for Health Care** is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information while you remain competent. If you want someone other than yourself to have access to that information now, while you remain competent, you need to complete and sign our HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

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This is a **General Authorization** form and should be filled out by patient or their personal representative, rather than the entity receiving or releasing the information. However, if you need help filling it out, we are happy to provide assistance.

**In Section 1** write **the name of health care provider** (hospital, physician, practice, etc.) **you are authorizing to *release* your information**, **and the name of person or entity authorized to *receive* the information**. You may use a single form to designate multiple persons or entities who are authorized to receive your information.

**In Section 2** indicate **time period** of information covered by the authorization.

**In Section 3** indicate **what information** is to be released.

**In Section 4** indicate how long the authorization is to remain **effective**, for example until a certain date or until a certain event. You have the right to revoke this authorization in writing at any time by notifying the entity you have authorized to release information.

Must be **signed by the patient** or their personal representative, such as a parent if patient is a minor.

**This General Authorization form may not be used for:**

- Authorizations to use PHI for Marketing
- Specific authorizations for *use* of PHI other than allowed by law
- Conditional authorizations relating to research or insurance benefits