HIPAA AUTHORIZATION & DISCLOSURE OF HEALTH INFORMATION

Date: ____________________

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: ____________________
Date of Birth: ____________________
Social Security #: ____________________

II. AUTHORIZATION. I authorize Hunterdon Neurology ("Authorized Party") to use or disclose the following:

☐ All of my medical-related information.
☐ My medical information ONLY related to: ____________________.
☐ My medical-related information from ______________to____________.
☐ Other: ____________________.

III. DISCLOSURE. The Authorized Party has my authorization to disclose medical records or health information to: (check ANY that apply to you)

☐ - ALL HEALTHCARE PROVIDERS THAT CURRENTLY PROVIDE CARE
☐ - FAMILY/FRIENDS/CAREGIVERS THAT CALL ON MY BEHALF – ONLY the following parties/persons/providers (NAME AND PHONE#):

____
____
____
____
____

This authorization is (check ANY that apply to you):

☐ General Purpose – allow access to any and all information
☐ To provide care and treatment. To allow the Authorized Persons/Physicians to communicate with the practice regarding my medical care and treatment.
☐ To obtain/send medical records on my behalf to and/or from another provider.
☐ Other: ____________________.

IV. AUTHORIZATION. This authorization will terminate (check one):

☐ - Until revoked by me in writing or this form is updated.
☐ - On the following date: ____________________.
☐ - Other: ____.

V. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ______________________________ Date: ____________________

Print Name: ______________________________________

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - Being a Minor. Patient is _______ years old and considered a minor under state law.

☐ - Being Incapacitated. Patient is incapacitated due to: ______________________________

☐ - Other: ____

Signature of Representative: ______________________________ Date: ____________________

Print Name: ______________________________

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: ______________________________