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)

1. ***Authorization***: I authorize Dr. Jasveer Grewal/Interventional Spine & Pain to use and disclose the protected health information described below to _____/Phone: _____

2. ***Effective Period***: This authorization for release of information covers the period of healthcare from:

a. _____ to _____. OR b. □ all past, present, and future periods.

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, except for the following records:

□Mental health records □Communicable diseases (including HIV and AIDS)

□Alcohol/drug abuse treatment □Other (please specify): _____.

OR

c. □No medical/billing records. Just pick up prescriptions

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. 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. 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.

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

8. 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.

Name of patient/personal representative & relationship to patient: _____

Signature of patient or personal representative: _____

Date: _____