

HIPAA AUTHORIZATION FORM A

Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, _____, hereby authorize Dr. Farahmand, M.D. to (check those that apply):

- use the following protected health information, and/or
- disclose the following protected health information to [Name of entity to receive information]:

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed for the following purposes: [List specific purposes here.]

This authorization shall be in force and effect until [specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure] at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to [Name of Privacy Contact] at [office address or e mail address].

I understand that a revocation is not effective to the extent that [Name of Practice] has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Dr. Farahmand, M.D. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- + Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- + Refuse to sign this authorization.

(The use or disclosure requested under this authorization will result in direct or indirect remuneration to the [Name of Practice] from a third party.) (If applicable.)

 _____ Date Signature of Patient or Personal Representative
 _____ Name of Patient or Personal Representative
 _____ Description of Personal Representative's Authority

(This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.) 2001 American Medical Association All Rights Reserved 11/09/01