

## HIPAA AUTHORIZATION FORM C

### Authorization for Use of Disclosure of Information for Research Purposes that Include Treatment

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

use the following protected health information, and/or

disclose the following information to [Name of entity to receive information and/or use 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.]

In addition, this protected health information may be used to carry out treatment, payment and health care operations of Dr. Farahmand, M.D. in the following manner:

[Describe how the protected health information will be used to carry out treatment and payment and health care operations purposes.]

We will not make the following disclosures that may be permitted under federal law. [describe disclosures not allowed]

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 such a revocation is not effective to the extent that Dr. Farahmand, M.D. 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.

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.

I have signed a consent form of Dr. Farahmand, M.D. and have been made aware of the Practice's Notice of Privacy Practices. The statements included in this authorization are binding on the Practice.

(The use or disclosure requested under this authorization will result in direct or indirect remuneration to Dr. Farahmand, M.D. from a third party.) (If applicable.)

\_\_\_\_\_ Signature of Patient or Personal Representative

\_\_\_\_\_ Date

\_\_\_\_\_ 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