HIPAA Privacy Authorization Form

\*Authorization for the Use or Disclosure of Protected Health Information

\*\*Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164

**AUTHORIZATION:**

I authorize Gainesville Family Practice, PC to use and disclose the protected health information described below to the following individuals:

**NAME RELATIONSHIP**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_ COMPLETE HEALTH RECORD

\_\_\_\_ OTHER (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_/ **Never Expires**.

I understand that I have the right to revoke this authorization at any time. This request should be made in writing. I understand that revoking this authorization does not make an effect on records previously disclosed to authorized individuals. Treatment and payment are not conditioned on whether I sign this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Name*

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*Signature* *Date*