INSIGHTFUL DIRECTION
YOUR JOURNEY, YOUR DIRECTION.

HIPAA AUTHORIZATION FORM

Patient's Full Name:_____ Patient's DOB: _____

Patient's Address: _____ City, State, Zip: _____

Patient's SSN/Medical Record Number:_____

Patient's Telephone Number: _____

I hereby authorize use/disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

   _____

2. The following person/class of persons may receive disclosure of protected health information about me:

   His/Her/Its Name: _____

   Address: _____

   City, State, Zip: _____ Telephone Number: _____

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

   _____

   Unless you sign below, no information about alcohol/substance abuse, HIV/AIDS, or mental health can be disclosed *

   YES, disclose this information: _____

   NO, do not disclose this information: _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Insightful Direction, LLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____
7. This authorization expires on date of: _____/_____/_20____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Note that signature is required in two places*

Signature of Individual*: _____

(The person about whom the information relates)

Date of Individual's Signature: _____

Date of Birth or Social Security Number: _____

OR, if applicable –

Signature of Guardian*: _____

(Or Personal Representative of Patient's Estate)

Date of Guardian's/Personal Representative's Signature: _____

Description of Authority to Act for the Individual: _____

A copy of this completed, signed, and dated form must be given to the Individual or other signatory.


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