HIPAA Authorization for PHI Use or Disclosure

[name of employer] [name of group health plan] (the "Plan")
HIPAA AUTHORIZATION FORM

Authorization for Use or Disclosure of Information

I hereby authorize the use and/or disclosure of my "Protected Health Information" (as defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")) as described below. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this authorization under my own free will.

I understand that once the authorized organization or person receives this information, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that the party making the use and/or disclosure (indicated in item A.3. below) is not responsible for ensuring that any recipient of my Protected Health Information will further use and/or disclose the information for the purposes listed below.

A. **Information to be used and/or disclosed and to whom**

1.

Period this authorization is valid: [time period].

2.

Name of individual whose Protected Health Information is the subject of this authorization: [name].

Individual's date of birth: [date of birth].

3.

Name or other specific identification of person(s) or organization(s) authorized to **use and/or disclose** the Protected Health Information: [person(s)/entity(ies)].

4.

If applicable, name or other specific identification of person(s) or organization(s) authorized to receive the Protected Health Information: [person(s)/entity(ies)].

5.

Specific description of Protected Health Information to be used and/or disclosed: [PHI description].

6.

Description of each purpose of the requested use and/or disclosure: [purpose(s) description].

B. **Compensation.**

Will the Plan receive financial or in-kind compensation or remuneration in exchange for using or disclosing the health information described above?

_______ No

_______ Yes (if yes, provide details): [compensation description, if any]

C. **Voluntary and Revocable Authorization**

I understand that this authorization is voluntary and I may refuse to sign it. I acknowledge that I have the right to revoke this authorization at any time by contacting the Plan's HIPAA Privacy Official. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use and/or disclosure have taken action in reliance on the authorization before it is revoked.

For more information on how to revoke this authorization, contact the Plan's HIPAA Privacy Official at [contact information].

D. **Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Execution of this Authorization**

I understand that the Plan may not condition treatment, payment, enrollment or eligibility for benefits on my executing this authorization.

E. **Signature**

By signing below, I acknowledge and affirm the statements in this authorization form and acknowledge that I have received a copy of the signed form.

____

Signature of [name of individual] or their representative

____

Date

If signed by a representative:

Print name of representative: ____

Relationship of representative (including basis of authority to act as personal representative):

____