diabetes & endocrine associates
2835 20th Street
Vero Beach, Fl 32960
Telephone: (772) 299-3003
Fax: (772) 299-3005

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act– 45 CFR Parts 160 and 164)

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

I, _____ hereby consent and authorize *Diabetes & Endocrine Associates of the Treasure Coast, LLC* to use and/or disclose my personal health information in the manner described below. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With this consent, *Diabetes & Endocrine Associates* may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders.

With this consent, *Diabetes & Endocrine Associates* may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as patient statements.

Diabetes & Endocrine Associates has the right to revise its Notice of Privacy practices at any time. I have been told that I am under no obligation to sign this authorization form and *Diabetes & Endocrine Associates* will not condition treatment or payment on my decision to sign this form. I have signed this form voluntarily.

My Authorization for Release of Information is covering the period of health care from:
□ _____ to _____ **OR** ☐ all past, present and future periods

Protected Health Information To Be Used and/or Disclosed
The following is a description of my personal health information that I authorize to be used and/or disclosed.
a. □ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
OR
b. □ I hereby ***authorize*** **the release of my complete health record** ***with the exception of the following information****:*
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify):

Entities Authorized to Use and/or Disclose

The following is a listing of the person(s) and/or organization(s) that I authorize to receive my personal health information as per the limitations listed above. I understand that if the person(s) and/or organization(s) listed below are not healthcare providers, a health plan, or a healthcare clearinghouse, that they are not subject to the same Federal privacy rules and that they may disclose my healthcare information without obtaining my permission.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Purpose of Use and/or Disclosure

The following is a description of the purpose(s) for which my healthcare information may be used and/or disclosed to the previously mentioned person(s) and/or organization(s) above.
The medical information may be used by the person(s) and or organization(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
Other purpose directed by me: _____

Expiration and Revocation

This authorization shall be in force and effect until:
□ Death
□ The expiration date of _____
□ Other occurrence listed related to patient _____

Right to Revoke

I understand that I have the right to revoke this authorization, in writing, at any time to the contact office below:

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I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature *(You may refuse to sign this authorization)*

I, _____, have had a full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

If this authorization is signed by a legal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT