HIPAA Authorization for Release of Protected Health Information

Name: _____

Date of Birth: _____ Telephone No: _____

Address: _____ City: _____

State: _____ Zip:_____

I hereby authorize _____ ("Covered Entity") to release my protected health information ("PHI") as that term is defined in the Health Insurance Portability and Accountability Act of 1996, *et seq.* ("HIPAA") to:

Name: Project LAND

Address: 1400 E. Angela Blvd., Suite 134, South Bend, Indiana 46617

Telephone No: (703) 431-1801

Fax No.:

The disclosure of medical records should include the following (please check all that apply):

___ Entire Medical Record (**excluding the information below, which require separate authorization)**

___ Entire Medical Record specific to the following dates: _____

___ Itemized Billing Statement ___ Medication Records

___ Office Visit Summaries ___All Consultations

___ Treatment Plans ___Other Information: _____

In addition, the following health information may be released or obtained from my medical record:

___ Information that may relate to treatment and/or history of psychiatric or mental health problems

___ Information related to dangerous communicable diseases, including AIDS, HIV and other infections

___ Information regarding treatment for chemical dependency

Service date(s) to be released: _____

The purpose of the requested disclosure is_____.

This release shall apply to any and/or all data listed above unless otherwise indicated as follows. Do not release information contained in my health record regarding: _____.

I understand that Covered Entity may not condition treatment, payment, or eligibility for benefits, as applicable, if I do not sign this Authorization. I understand that this Authorization is voluntary, and consent can be revoked at any time, except to the extent that a disclosure made in good faith has already occurred

in reliance on this Authorization. I further understand this information may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

This Authorization is valid for twelve (12) months, unless revoked sooner by sending written notice to Covered Entity at the following address:

_____

_____

I acknowledge that I have been provided a copy of this Authorization, except if I have personally initiated the Authorization request. I acknowledge, by signing this authorization that there may be a charge for copies of my health information as allowed by State and Federal laws. If Covered Entity sends records directly to another physician for treatment continuity, there is no charge. There may be a charge for all other requests.

_____ _____/_____/_____
Patient's Signature Date

_____
Printed Name of Patient

If Patient is under 18 or Personal Representative of Patient:

_____ _____/_____/_____
Parent, Guardian, or Personal Representative's Signature Date

_____
Printed Name of Parent, Guardian, or Personal Representative

Description of Parent, Guardian, or Personal Representative's authority to sign this Authorization:

_____

_____

FOR OFFICE USE ONLY

Revocation Date: _____
Processed By: _____
Signature: _____