

## HIPAA Privacy Authorization and Release of Information Form

**\*\*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)\*\***

**Patient Name:** \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

1. I authorize \_\_\_\_\_ (healthcare provider) to release and disclose the protected health information described below to:

**Lemont ENT, SC, 1011 State St., Ste. 120, Lemont, IL**  
**Fax no: 630-243-4505**

2. This authorization for release of information covers the period of healthcare from:

a.  \_\_\_\_\_ to \_\_\_\_\_.

3. a.  I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) **\*\*OR\*\***

b.  I 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): \_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_ (date or event) at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. 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.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. 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 of patient or personal representative

\_\_\_\_\_  
Printed name of patient or personal representative and his or her relationship to patient

\_\_\_\_\_  
Date