

**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE  
OF HEALTH INFORMATION**

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

- Type of Government Issued ID Attached: \_\_\_\_\_

**I. My Authorization**

I authorize the following using or disclosing party:

**PEDIATRIC CARE OF OGDEN**

**to use or disclose the following health information.**

- All of my health information

- My health information relating to the following treatment or condition:

\_\_\_\_\_

- My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

- Other: \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name (or title) and organization \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

- Type of Government Issued ID Attached: \_\_\_\_\_

**The purpose of this authorization is (check all that apply):**

- At my request

- Other: \_\_\_\_\_

**This authorization ends:**

- On (date) \_\_\_\_\_

- When the following event occurs: \_\_\_\_\_

**II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient:** \_\_\_\_\_

Date: \_\_\_\_\_

**III. Additional Consent for Certain Conditions**

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.
- I do not consent to have the above information released.

**Signature of Patient:** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**IV. Additional Consent for HIV/AIDS**

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- I consent to have the above information released.
- I do not consent to have the above information released.

**Signature of Patient :** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

PCO Witness:
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