AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

In accordance with the Privacy Rule of the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I understand that:

- 1. This Authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under Federal or State Law. I understand that I have the right to a list of people who may receive or use my HIV-related information without authorization.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAT THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this	s information:	
8. Name and address of person(s) or category of person to who	m this information will be sent:	
9(a). Specific information to be released:		
{ } Medical Records from (insert date)	to (insert date)	
 { } Medical Records from (insert date) { } Entire Medical Record, including patient histories, office notes films, referrals, consults, billing records, insurance records and 	records sent to you by other health care providers.	
{) Other:	Include: (Indicate by Initialing)	
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information (b). { } By initialing here I authorize	HIV-Related Information	
(b). { } By initialing here I authorize		
	(Name of individual health care provider)	
to discuss my health information with my attorney, or a g	overnmental agency, listed here:	
(Attorney/Firm Name or Government)	mental Agency Name	
10. Reason for release of information: { } At request of individual { } Other:	11. Date or event which this authorization will expire:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Signature of patient or representative authorized by law	Date	

INSTRUCTIONS FOR THE USE OF THE HIPAA COMPLIANT AUTHORIZATION FORM TO RELEASE HEALTH INFORMATION NEEDED FOR LITIGATION

This form was designed to produce a standard official form for Preferred Mutual Insurance Company that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) and its regulations, to be used to authorize the release of health information in the processing and/or settlement of injury claims.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my bodily injury claim" or provide a specific date of time, such as "3 years from today's date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.