Patient Name: _____

HIPAA Privacy Authorization for Release of Records to Midwest Aortic & Vascular Institute, P.C.

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164.)

Authorization

I authorize (Choose One)

____ any provider/hospital

____ only the provider(s)/hospital(s) listed below

_____

_____

_____

to disclose the health information described below to Midwest Aortic & Vascular Institute, P.C.

Effective Period

This authorization covers the period of healthcare from:

☐ _____ (date) to _____ (date) OR

☐ all past, present and future periods.

Extent of Authorization (Choose One)

☐ 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

☐ 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) _____

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. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires. 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. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 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/Guardian/DPOA Date Signed