**FirstMed Family Healthcare**

**HIPAA PRIVACY**

**AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as “HIPAA”). This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize FirstMed Family Healthcare of health to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that I am entitled to a copy of Notice of Privacy Standards.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drugs abuse.

**Permission to Disclose Medical Information to Family Members**

I give permission for FirstMed Family Healthcare to disclose any necessary medical information with the following family members if I am unable to discuss the information personally. I also understand that ONLY the family members below will be given my medical information if a situation warrants it.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Guardian/Minor Treatment Permission**

As the legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I give permission to FirstMed Family Healthcare treat the patient without my presence at the time of treatment.

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Signature Print

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: December 31, 2020

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include: Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker’s Compensation.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Relationship to patient, if patient is unable to sign or minor