

Authorization for Use or Disclosure of Protected Health Information (HIPAA)

Northwest Psychiatry

This form is based on the U.S. Department of Health and Human Services HIPAA Authorization (IHS-810).

I. Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/ZIP: _____

Medical Record Number (if known): _____

II. Authorization

I hereby authorize Northwest Psychiatry to use or disclose the following protected health information as described below.

III. Information to Be Disclosed

- Entire medical record
- Only records related to: _____
- Records for dates of service from: _____ to _____
- Other (specify): _____

Sensitive information (check only if you want it included):

- Mental health records (excluding psychotherapy notes unless specified)
- Psychotherapy notes
- Alcohol/drug abuse treatment records
- HIV/AIDS or STD-related information

IV. To Whom the Information May Be Disclosed

Name/Organization: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

V. Purpose of Disclosure

Continuing care

Personal use

Insurance/Payment

Legal/Attorney

Other (specify): _____

VI. Expiration and Revocation

This authorization will expire on (date or event): _____.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

VII. Acknowledgment

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA, except for information protected by 42 CFR Part 2.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, except as allowed by law.

VIII. Signatures

Patient Signature: _____ Date: _____

If signed by personal representative, relationship to patient: _____

Witness (if required): _____ Date: _____