HIPAA PRIVACY AUTHORIZATION FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

MRN #: _____

I hereby authorize Arroyo Vista Family Health Center (AVFHC), to release all existing medical records and information regarding the above referenced patient's medical care, treatment, physical/medical condition, and medical expenses revealed by your treatment of the patient

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

I understand that this authorization includes information regarding the diagnosis and treatment of drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), and psychiatric and psychological disorders except Psychotherapy Notes. This authorization also gives the listed person/persons access to laboratory reports, Diagnostic reports, discharge summaries, photographs surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes, prescriptions, medical and any correspondence/memoranda and billing information.

I, the undersigned individual, am on notice that:

- Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.

- This authorization can be revoked through written notice to listed individuals, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.

I have carefully read and understood the HIPAA privacy authorization, and hereby voluntarily authorize the disclosure of my medical information and records to the persons you have identified.

Date: _____

Patient or Legal Patient Representative

_____

(Signature)

Name of Patient's Legal Representative

_____

Description of Legal Representative's Authority to Act for the Patient

_____

This authorization is designed to comply with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164. *Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.