You are entitled to keep your health information private. The HIPAA Privacy Authorization Form should be completed if you would like some person other than yourself to have access to your medical records information. This form gives your health care provider written authorization to release your health information to the persons you have named.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information pursuant to
the Health Insurance Portability and Accountability Act ---- 45 C.F.R. Parts 160 and 164

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to Seaside Rehabilitation.
2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date) _____ **OR**
   b. ☐ all past, present and future periods. (check this box to include all of your medical records.)
3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). **OR**
   b. ☐ my complete health record with the exception of the following information (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____
4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize Seaside Rehabilitation to disclose information regarding my billing, condition, treatment and prognosis to third parties to the extent Seaside Rehabilitation needs to do so in order to determine my eligibility for statutory benefits, in connection with any legal proceedings or prospective legal proceedings, in order to establish, exercise or defend its legal rights, for the purpose of fraud detection and prevention or as required and permitted to do so by law.
5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. This authorization shall be in force and effect until _____, (date or event) at which time this authorization expires.
7. 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 statutory benefits from the Seaside Rehabilitation.
8. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. 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 or personal representative Date:

_____

Printed name of patient or personal representative and his/her relationship to patient