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HIPAA Compliant Authorization Medical Release Form

Authorization for Use of Disclosure of Protected Health Information

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

I authorize _____ (health care provider / hospital) to use and disclose the protected health information described below to Lynn E. Nauman, MD at In Good Hands.

This protected health information includes information contained in my medical records, which may include, and may not be limited to my history and physical, discharge summary, medical history, lab results, radiology results, and my physician's diagnosis and treatment. I understand the information to be released or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or HIV, alcohol and drug dependence and/or abuse.

I authorize the release or disclosure of this type of information.

This authorization shall be in full force and effect for 180 days at which time this Authorization for Use and Disclosure of Protected Health Information expires.

The person I authorize to receive this information may use this medical information as I may direct for medical treatment, consultation, billing, claims payment or other purposes.

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 activated in reliance on my authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditions of 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.

_____ _____

PATIENT SIGNATURE PATIENT DATE OF BIRTH

_____ _____

PATIENT PRINTED NAME TODAY'S DATE