HOLISTIC HEALTH
ASSOCIATES

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

□ There are no other affiliated parties that I require to have access to my health information

****CHECK BOX ABOVE OR COMPLETE THE FOLLOWING BELOW****

1. **AUTHORIZATION**
   I, _____, authorize Holistic Health Associates to use and disclose the protected health information described below to the following person(s) or health care professional(s):
   (First and Last Name)

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. **DATES OF SERVICE (check one)**
   This authorization for the release of information covers the period of healthcare from:

   □ _____/_____/_____ to _____/_____/_____
   ****OR****
   □ All past, present and future periods.

3. **EXTENT OF AUTHORIZATION (check one)**
   □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and the treatment of alcohol or drug abuse).
   ****OR****
   □ I authorize the release of my complete health record with the exception of the following information:
   - Mental Health Records
   - Communicable diseases (including HIV and AIDS)
   - Alcohol/drug abuse treatment
   - Other (please specify): _____

4. **EXPIRATION**
   Unless sooner revoked, this authorization expires **one year** from the date this authorization is signed, or as otherwise indicated here: _____.

5. **REVOCATION**
   I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to **Holistic Health Associates at 603-B West Patrick Street, Frederick, MD 21701**. I understand that a revocation is not effective to the extent of any person or entity that has already acted in reliance on my authorization or if my authorization was acquired as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. This medical information may be used by the person(s) or health care professional(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization form.

8. I understand that protected health information (PHI) used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law privacy regulations.

_____ _____/_____/_____
Signature of Patient or Personal Representative **Date**

_____ _____
Printed Name of Patient or Personal Representative **Relationship to Patient**