Killeen Psychiatry — HIPAA Privacy & Release of Information Authorization

Patient name	Date of birth	Date

1. Consent & Authorization

HIPAA Privacy/ Request of Information 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)

1. Authorization: I authorize the following health care professional to use and disclose the protected health information described below to Killeen Psychiatry.

2. Effective Period: This authorization for release of information covers the period of healthcare from:

3. Extent of Authorization: I authorize the release of my complete health record (including records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) to be used for treatment and diagnosing purposes.

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until date for one year from the date of signing below

6. 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 entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage & the insurer has a legal right to contest a claim.

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

8. 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.

Killeen Psychiatry 4904 Trimmier Rd, Killeen, TX 76542 Phone: 254-236-3364 Fax: 254-488-3038

Name of person or provider you authorize us to share information with or receive information from (example: previous doctor, yourself, spouse, parent, etc.):

Previous Provider's or Authorized Personnel's Phone Number:

Previous Provider's Fax Number:

Dates of care:

Name: (required)

DOB: (required)
MM/DD/YYYY

Date: (required)
MM/DD/YYYY

Signature

Signature of patient or legal representative _____ Date _____

Printed name _____

If signing for the patient, your relationship to the patient _____