HIPPA 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.

1. **Authorization**

   I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Caroline Jaffee and C2-It, LLC.

2. **Effective Period**

   This authorization for release of information covers the period of healthcare from:

   a. ☐ _____ to _____.

   OR

   b. ☐ all past, present, and future periods.

3. **Extent of Authorization**

   a. ☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and the treatment of alcohol or drug abuse).

   OR

   b. ☐ 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. This 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 or event), at which time this authorization expires.

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

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

8. I understand that my 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   Patient