HIPAA Privacy Authorization Form

I, ______________________________ ______________ give permission to: ______________________________

Patient Name — Date of Birth — Name of Facility

To disclose and release my Protected Health Information (PHI) to the following individual(s):

Name	Address, City, State, Zip and Telephone	Relationship

I authorize the release of PHI for the following timeframe:

From ____________________ To: ________________ -OR- ☐ All past and future dates

Start Date — End Date

The following PHI can be disclosed (check all that apply):

☐ My complete health records (including: mental health, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse, diagnosis, lab tests, prognosis, treatment, and billing for all conditions)

☐ My complete health records, as above, with the exception of the following information (check all that apply)

- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Genetic counseling/Testing information
- ☐ Communicable diseases (including HIV, AIDS and STD)
- ☐ Other: ____

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Patient Name:____________________ **Date of Birth:**____________________

I understand the following:

This authorization is valid for information already in my medical record and any information added while this authorization is effective.

I may request to see this information during normal business hours.

I can withdraw my approval by completing the **Revocation of Authorization** form at any time. The **Revocation of Authorization** form does not apply to:

- Information that has already been released during this authorization.
- My insurance company when the law provides my insurer the rights to contest a claim under my policy

Authorizing this disclosure of information is voluntary and I can refuse to sign

I do not have to sign this form to receive treatment.

This medical information may be used by the persons I authorize to receive this information for:

- Medical treatment or consultation
- Billing or claims payment
- Other purposes as I may direct

- If the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal state laws that require the information to remain confidential.

Unless otherwise revoked, this authorization will expire **12 months** following the date of signature.

I acknowledge that I have read this form or it has been read to me and I understand its content.

Signature ____ **Date** ________________________

Relationship to Patient:

If signed by a person other than yourself, please check the relationship and provide proof of authority.

☐ Self ☐ Legal Representative* ☐ Parent of Minor Child ☐ Other (specify)

____ ________________________

****Name of Interpreter/Translator (If Required)** **Telephone**

***If signed by a person other than yourself, please check the relationship and provide proof of authority to do so.**

****If a translator or interpreter was required.**

OFFICE USE ONLY

________________________ ________________________ ____________

Office Personnel Name (Print) **Signature** **Date**

CenterWell

HIPAA Privacy Authorization Form

Important!

At CenterWell Senior Primary Care, it is important you are treated fairly.

CenterWell Senior Primary Care (CenterWell) does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. CenterWell complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CenterWell, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-2188** or if you use a **TTY**, call **711**.

- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

CenterWell provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어(Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید. **Diné Bizaad**
ËNavajoЋ: W0dahٰ b44sh bee haniʼٰ bee woltaʼٰgٰٰ bichʼ9ʼ h0dٰٰlnih 4ٰ bee tʼ11 jiikʼeh saad bee 1k1ʼ1nٰdaʼ1woʼd66 nik1ʼadoowo[.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220