Compton Care, LLC
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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 Compton Care to [ ] OBTAIN [ ] RELEASE medical information via mail, facsimile, or other appropriate source [ ] TO [ ] FROM:

_____

(Person(s) or Entity(s) to receive/ release requested information)

_____

(Address) (City, State, Zip) (Phone Number) (Fax Number)

2. Effective Period

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

□ _____ to _____

□ All past, present, and future periods

3. Extent of Authorization

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

□ I authorize the release of my complete health record with the exception of the following:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

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 will expire on _____ (please indicate expiration date or specific event)
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 consent 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.

_____ _____ _____

Print Name Signature Date

For Office Use Only: Authorization received/verified by: _____on _____.

Copy of Authorization form given to patient [ ] YES [ ] NO/Authorization fulfilled and information sent: _____