

WOMBA - HIPAA AUTHORIZATION FORM

Patient's Full Name	Patient's Social Security Number/Medical Record Number
Address	Patient's Date of Birth
City, State Zip Code	Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

2. The following person (or class of persons) may receive disclosure of protected health information about me:

His/her/its Name
Address
City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION * _____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires on _____, 200____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with WoMBA to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates) <i>OR, if applicable –</i>	Date of Individual's Signature	Date of Birth or Social Security Number
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Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual
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A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only		
Received	Processed By	Log #