

# HIPAA PRIVACY AUTHORIZATION FORM

## Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act (HIPAA) – 45 CFR Parts 160 and 164)

1. I, \_\_\_\_\_, hereby authorize \_\_\_\_\_,  
(Patient Name or Patient's Representative) (Facility Name)  
to release copies of my complete and protected medical records and other health information concerning my diagnosis and treatment, for the purpose of filing claims, as described below:

Billing Records  
Discharge Summary  
Physician Orders  
History  
Progress Notes  
Laboratory Reports  
Consultation Report  
EEG Report

Radiology Reports  
Psychiatric/Psychological Evaluation/Conditions  
Alcohol and Drug Abuse Treatment  
Communicable Diseases (Including HIV/AIDS)  
Additional information as requested by the  
medical director  
Other \_\_\_\_\_

The above information is to be released to **Frontier International Group:**

**Address:**

Frontier International Group  
PO Box 613  
Milwaukee, WI 53201

**FAX:**

(949) 666-8700

2. This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire one hundred eighty (180) days after the date below, or sooner by choice, in which case this consent will expire on \_\_\_\_\_.

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. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed to my Insurance Company by the recipient and may no longer be protected by federal or state law.

3. Patient's Name \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

Signature of Patient or Representative \_\_\_\_\_ Today's Date \_\_\_\_\_

Relationship to Patient (if Representative) \_\_\_\_\_ Signature of Witness \_\_\_\_\_

**To Fill-In The Form:**

In **Item 1** enter the patient's name or the name of the patient's representative and the name of the health care provider (hospital, physician, etc.) who is authorized to release the information.

In **Item 2** enter a date when this authorization will expire, **or** leave it blank to allow the authorization to expire in 180 days.

In **Item 3** enter the patient's name and the patient's date of birth. The patient or the patient's representative must sign the form. Enter the current date ("Today's Date"). If a patient's representative signs the form enter the relationship between the patient and the representative. A witness must sign the form.