

HIPAA Privacy Authorization Form

*Southern Wellness, LLC*

Authorization for use or disclosure of protected health information.

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

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list names and relationships of all persons that you authorize *Southern Wellness, LLC* to release your medical information to during the course of your care:

|  |  |
| --- | --- |
| Name | Relationship |
|  |  |
|  |  |
|  |  |

**I hereby authorize all medical sources to release and disclose the following protected health information to:**

Southern Wellness, LLC Southern Wellness, LLC

2969 C Pelham Parkway 5510 Hwy 280 S, Suite 216

Pelham, Alabama 35124 Birmingham, Alabama 35242

Fax 205-620-6776 Fax 205-620-6776

**Specific information to be disclosed:**

**\_\_\_\_Entire Medical Record**

**\_\_\_\_Only information related to (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_Only the period of events from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_Other (please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The information for which I am authorizing disclosure will be used for the following purpose:**

**\_\_\_\_Further Medical Care**

**\_\_\_\_My Personal Use**

**\_\_\_\_Other (please describe)**

**Important Information About Your Rights**

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, drug testing and screening or any such related information. I understand that the health information released may be subject to re-disclosure by Southern Wellness physicians and no longer protected by the Federal Privacy Rules. By signing this form, I am consenting to the use and disclosure of my protected health information to carry out treatment, payment, health care operations, or other purposes as I may direct or as permitted by law to the above individuals. I have the right to request that Southern Wellness, LLC restrict how it uses or discloses my protected health information to carry out treatment, payment, and health care operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I may revoke this authorization, in writing, at any time by sending a written request to Southern Wellness, LLC. The revocation must be signed and dated, and mailed to Rebecca Halechko, Southern Wellness, LLC. The revocation will not have any effect on any uses or disclosures prior to the receipt of the revocation. This authorization will expire one calendar year from the date signed unless otherwise specified.

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Signature of Patient/Patient Representative Date

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Printed Name of Patient/Patient Representative Relationship to Patient

\_\_\_\_ (Initial) I acknowledge that I have been provided a copy of Southern Wellness’s Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information. Ro05.332.3160 | fax :: 866.702.0880 | www.ncpmr