[Insert Facility Name]

HIPAA AUTHORIZATION
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FORM

Resident Name:		
Address:		
DOB:	SSN:	MRN:

1. I hereby authorize the Facility to use and/or disclose the above-named individual's health information as described below.
2. The PHI that may be used and/or disclosed is (check all that apply):
   - __ Entire Medical Record
   - __ Entire Medical Record for specific dates: _____ to _____
   - __ Specific sections of the medical record (e.g. medications, x-rays, etc.) _____
   - __ Photographs or other audio-visual images for use on the facility's social media or other marketing materials
   - __ The following categories of PHI may be included only if selected here:
     - Alcohol/Drug Treatment
     - Mental Health information
     - HIV-related information
   - __ Other: _____
3. The PHI specified above may be used or disclosed to Entity(s)/Individual(s): _____
4. The PHI may be used and/or disclosed for the following purpose(s):
   - __ At the request of the resident
   - __ Other purpose: (e.g. life insurance request, social media, legal request) _____
5. This authorization shall remain in effect until either:
   __ Expiration Date_____ __ Expiration Event_____
6. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form, unless circumstances are present.
7. I understand that, as set forth in the Notice of Privacy Practices and the Facility's Policies and Procedures, I have the right to revoke this authorization, in writing, at any time, except to the extent that the Facility has acted in reliance upon it, by sending written notification to the Facility at the following address:
   _____Facility Address_____
8. I understand that I have the right to refuse to sign this authorization.
9. I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

_____ _____
Resident Signature Date

_____ _____
Resident's Personal Representative Description of the representative's authority to act on behalf of the resident