SPRINGFIELD FAMILY MEDICAL CENTER

123 Medical Plaza Drive • Springfield, IL 62701 • Phone: (555) 123-CARE

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE: This form complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Your health information is protected by federal law. This authorization allows us to use and disclose your health information for the purposes described below.

PATIENT INFORMATION

Patient Name

Date of Birth

AUTHORIZATION FOR DISCLOSURE

I authorize Springfield Family Medical Center to use and disclose my health information for the following purposes:

- ☐ **Treatment: To provide, coordinate, or manage health care and related services**
- ☐ **Payment: To obtain payment for health care services provided**
- ☐ **Health Care Operations: To support business activities such as quality assessment and improvement**

PERSONS/ENTITIES AUTHORIZED TO RECEIVE INFORMATION

I authorize the disclosure of my health information to:

- ☐ **Insurance companies for payment and coverage determination**
- ☐ **Other healthcare providers involved in my care**
- ☐ **Family members or personal representatives as specified below**

Specific persons authorized to receive health information (Name and relationship)

PATIENT RIGHTS

I understand that:

- • I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization.
- • Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon my signing this authorization.
- • Information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal privacy regulations.
- • I may inspect or copy the health information to be used or disclosed as permitted under federal law.
- • I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

EXPIRATION

☐ **This authorization expires upon termination of treatment or patient relationship**

☐ **This authorization expires on the following date:**

COMMUNICATION PREFERENCES

How would you prefer to be contacted regarding appointments and test results?

☐ **Phone** ☐ **Email** ☐ **Mail** ☐ **Patient Portal**

☐ **It is okay to leave detailed messages on my voicemail**

By signing below, I acknowledge that I have read and understand this authorization and agree to its terms.

Patient Signature (or Personal Representative)

Date

If signed by Personal Representative, indicate relationship and authority

You may request a copy of this signed authorization