HIPAA Authorization Form

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable.

Section 1 – Patient/Plan Member Information

Last Name: Foley

First Name: Connie

Middle Name: Alexis

Reference N°: MRN96264 Date of Birth: 1953-04-17

Address: 6135 Michael Junctions

City/State/ZIP: Lake Margaret/New York/02647

Section 2 - Individual/Organization Authorized by Signatory to Disclose PHI

Name: Dr. Marissa Sawyer

Address: 74165 Karen Valley Suite 596

City/State/ZIP: Elizabethborough/New York/2170

Section 3 - Individual/Organization Authorized by Signatory to Receive PHI

Name: Jeffrey Foley

Relationship to Patient/Plan Member: Spouse

Telephone N°: 001-750-826-2964

Address: 6135 Michael Junctions

City/State/ZIP: Lake Margaret/New York/02647

Section 4 - Authorization Expiration Event or Date

Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing.

Expiration Event: N/A Expiration Date: 2026-10-27

Section 5 – Health Information to be Disclosed - General

I authorize the following Protected Health Information to be disclosed:

Medical Records Dental Records Other Non-Specific

If Other Non-Specific, provide details:_____

Section 6 – Health Information to be Disclosed – Specific

I authorize the following Protected Health Information to be disclosed:

Communicable Disease	Signature: Connie Foley	Date: 2025-10-27
Reproductive Health	Signature: Connie Foley	Date: 2025-10-27
HIV Test Results	Signature: Connie Foley	Date: 2025-10-27
Mental Health Records *	Signature: Connie Foley	Date: 2025-10-27
Substance Use Disorder	Signature: Connie Foley	Date: 2025-10-27
Other	Signature: N/A	Date: N/A

If "Other", provide details:

_____

*** Requests for psychotherapy notes require a separate HIPAA Authorization Form and may not be combined with any other request.**

Psychotherapy Notes	Signature: Connie Foley	Date: 2025-10-27

Section 7 - Purpose of the Release or Use of Health Information

Healthcare Research Marketing Sale Legal

Other (please specify): _____

Note: The sale of PHI authorized by this HIPAA Authorization Form will result in remuneration to the party specified in Section 2.

Section 8 - Authorization Information

I understand the following:

1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information by the party specified in Section 2 from the date of receipt. I understand a delay may exist if the party specified in Section 2 is not the covered entity authorized to disclose Protected Health Information to the party specified in Section 2. I also understand that a written revocation is not effective with respect to actions the covered entity or party specified in Section 2 took in reliance on a valid Authorization, or where the Authorization was obtained as a condition of obtaining insurance coverage.

3. I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.

4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations.

5. I have a right to receive a copy of this HIPAA Authorization Form.

6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

Section 9 - Additional Conditions that Apply to this HIPAA Authorization Form

Section 10 - Signature by or on Behalf of Patient/Plan Member
Name of Patient/Plan Member (Print): Connie Foley
Signature: Connie Foley Date: 2025-10-27
Name of signatory if not patient/plan member: N/A
Authority to sign on behalf of patient/plan member: N/A
Name of translator (if applicable): N/A
Signature of translator (if applicable): N/A