# 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: Thomas

First Name: Courtney

Middle Name: N/A

Reference N°: MRN7994 Date of Birth: 1954-10-01

Address: 06773 Peter Bypass Apt. 616

City/State/ZIP: Leeland/Montana/14249

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

Name: Dr. Jonathan Poole

Address: 48309 Courtney Manor Suite 204

City/State/ZIP: Scottborough/Montana/14453

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

Name: Debbie Thomas

Relationship to Patient/Plan Member: Parent

Telephone N°: 342-285-5389

Address: 06773 Peter Bypass Apt. 616

City/State/ZIP: Leeland/Montana/14249

## 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: Patient revocation Expiration Date: N/A

## 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: Courtney Thomas | Date: 2025-10-27 |
| Reproductive Health | Signature: Courtney Thomas | Date: 2025-10-27 |
| HIV Test Results | Signature: Courtney Thomas | Date: 2025-10-27 |
| Mental Health Records * | Signature: Courtney Thomas | Date: 2025-10-27 |
| Substance Use Disorder | Signature: Courtney Thomas | 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: Courtney Thomas  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): Courtney Thomas |
| Signature: Courtney Thomas 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): Chelsey Taylor |
| Signature of translator (if applicable): Chelsey Taylor |