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HIPAA Privacy Authorization Form

I authorize Rodney P. Coe, M.D. to use and disclose the protected health information described below to:

Name: _____

Phone Number: _____ **Relationship:** _____

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultations, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force indefinitely unless I indicate an expiration date.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this attestation.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient/representative **Date**

_____

Printed name of patient/representative

_____

Relationship to patient