HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act of 1996
(HIPAA) Privacy Standards

Print Name of Member: _____

Date of Birth: _____ Address: _____

I, the member or the member's authorized representative, authorize **HEALTHMAP SOLUTIONS** to use and/or disclose the protected health information described below to (the "Recipient"):

_____

Printed Name *Phone Number*

_____

Address *City* *State* *Zip Code*

The authorization covers uses and disclosures the following health information: (check one)

☐ All past, present, and future periods, **OR**

☐ For the period of health care from _____ to _____, **OR**

☐ My health information relating to the following treatment or condition: _____

Additional Consent for Certain Conditions

This medical record may contain information **about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.**

☐ I consent to have the following information released:
- ☐ Physical or sexual abuse
- ☐ Alcoholism, drug, and substance
- ☐ Sexually transmitted diseases
- ☐ Abortion
- ☐ Mental health treatment
- ☐ Genetic information, including genetic test results

☐ I do not consent to have information released regarding these certain conditions.

Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

This medical information may be used by the Recipient for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

1. This authorization shall be in force and effect until _____, at which time this authorization expires.
   Date authorization will expire
   OR life event such as death.

2. I understand that I have the right to revoke this authorization, in writing, at any time by emailing compliance@healthmapsolutions.com. 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.

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

4. 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.

5. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

For California and Texas Members ONLY:
If the member resides in California or Texas, or treatment was rendered in California or Texas, please complete the following section. The release shall be limited to the following types of information:

- ☐ **Entire record, no limitation**
- ☐ Provider's orders
- ☐ Progress notes
- ☐ History/Physical exam
- ☐ Member allergies
- ☐ Diagnosis
- ☐ Past/Present medications
- ☐ Social history
- ☐ Individual treatment plan
- ☐ Legal information
- ☐ Medical assessments (e.g., EKG)
- ☐ Lab and test results
- ☐ Billing information
- ☐ Other (please specify): _____

SIGNATURE AUTHORIZATION for Texas members: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE

_____	_____	_____
Signature of Member (The person about whom the information relates)	**Print Member's Name**	**Date**

OR

If this form is being completed by a **person without legal authority to act on the member's behalf** because the member is illiterate or incapacitated, please complete the following information:

OR

_____	_____	_____
Signature or Mark on Behalf of Member	**Print Name of Individual Acting on Member's Behalf**	**Date**

OR

If this form is being completed by a **person with legal authority to act on the member's behalf**, such as a parent or legal guardian, a health care agent, or an individual acting pursuant to a power of attorney or court order, please complete the following information:

_____	_____	_____
Signature of Individual with Legal Authority	**Print Name of Individual with Legal Authority**	**Date**

Please describe this person's legal authority to sign on behalf of the member:

_____
_____
_____
_____

If you believe that Healthmap Solutions Inc. has failed to protect your protected health information or you have a question or concern you would like Healthmap to address, please notify the Privacy Officer by writing to the Privacy Officer at Healthmap Solutions Inc., 4631 Woodland Corporate Blvd, Suite 201, Tampa, FL 33614, or via email at compliance@healthmapsolutions.com and/or call 1-877-546-7004 or if you use a **TTY**, call **711.**