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 authorize **HEALTHMAP SOLUTIONS** to use and/or disclose the protected health information described below to:

_____

Printed Name *Phone Number*

_____

Address *City* *State* *Zip Code*

To use or disclose 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 above information released.
- ☐ I do not consent to have the above information released.

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 person I authorize to receive this information 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 or Event

2. 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.

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.

_____ _____

Signature of Member or Personal Representative *Date*

_____ _____

Print Name of Member or Personal Representative *Relationship to Member*

If the member is a minor OR unable to sign, please complete the following:

☐ Member is a minor: _____ years of age

☐ Member is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the Member:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Power of Attorney ☐ Other: _____

If you believe that Healthmap Solutions, Inc. has failed to protect your protected health information (PHI) 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, via email at compliance@healthmapsolutions.com, and/or by calling 1-877-546-7004 or if you use a **TTY**, call **711.**