



HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. AUTHORIZATION

I authorize Wooten Healthcare Group to use and disclose the protected health information described below to _____

2. EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from :

___ a. _____ to _____.

OR

___ b. all past, present and future periods.

3. EXTENT OF AUTHORIZATION

___ a. 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).

OR

___ b. I authorize the release of my complete health record with the exception of the following information:

___ Mental health records

___ Communicable diseases (including HIV and AIDS)

___ Alcohol /drug abuse treatment

___ Other (please specify): _____