HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability an 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 an AIDS)

____ Alcohol /drug abuse treatment

____ Other (please specify): _____