

HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name _____
(Printed)

I hereby authorize Varipro to use or disclose my protected health information to
(Discloser)

(Name and relationship of person)

****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):

NOTE: If “b” is selected you must choose or specify the information you are not authorizing to release.

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Date

Signature of Individual or Representative

Authority or Relationship to Individual, if Representative

EXPIRATION DATE: This authorization will expire on _____

If no date or event is stated, the expiration date will be **ONE** year from the date of this authorization.

Copy provided upon request.