Important Information about HIPAA Authorizations and Personal Representatives

The HIPAA Privacy Rule requires **[FACILITY]** to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care.

You have the right to authorize that the PHI held by **[FACILITY]** be released to and/or received by persons or organizations you identify. The person or organization you identify on the HIPAA Authorization **or** the Personal Representative Request Form may not be subject to the HIPAA Privacy Rule. If this is the case, your appointed Personal Representative, or those authorized to use or disclose your protected health information may further release your confidential information without protection from federal or state privacy laws.

Appointing a Personal Representative, or authorizing the use and/or disclosure of your protected health information is voluntary.

[FACILITY] will not treat someone as your Personal Representative if (1) we reasonably believe you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), we decide that it is not in your best interest to treat the person as your Personal Representative.

To assist **[FACILITY]** in responding to your request to authorize the use and/or disclosure of your protected health information or to appoint a Personal Representative, please complete **one** of the following forms by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. If you are giving permission to **[FACILITY]** to share the PHI of your minor child (ren), please complete the applicable section of the Personal Representative form below.

Please email the completed form of your choice to: facilityemail@tenethealth.com

or

Mail or fax the completed form and supporting documentation to:

[FACILITY]
Street Address
City, State, Zip
Fax: (123) 456-7890

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act ----- 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to my agent identified in my durable power of attorney for health care named ____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _________________ - to (date) ______________________ **OR**
   b. ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse); **OR**
   b. ☐ my complete health record ***with the exception of the following information*** (Check as appropriate):
      - ☐ Mental health records
      - ☐ Communicable diseases (including HIV and AIDS)
      - ☐ Alcohol/drug abuse treatment
      - ☐ Other (please specify): ____________________________________; **OR**
   c. ☐ Limited to information listed: ______________________________________.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name ______________________________________ Relationship _____________________

Name ______________________________________ Relationship _____________________

Name ______________________________________ Relationship _____________________

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or __________________________________, (date or event) at which time this authorization expires.

7. 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.

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

9. 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.

______________________________________	____________________
Signature of Patient or Legal Representative	Date

Keep original, and give copies to your health care provider, agent and family members

If you have any questions about this form, please contact **[FACILITY]** at (123) 456-7890.