Restore Medical Fitness
4545 Transit Rd.
Williamsville, NY 14221
716-906-2102

HIPAA Compliance Office
Maria Kreher

F-1006 HIPAA – Privacy Authorization

PATIENT INFORMATION

Date

Name (Last, First, Middle initial) | Date of Birth

Street address, City, ST, ZIP Code | Email address

Primary phone number | Other phone number | Fax number

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)

Authorization

I authorize Restore Medical Fitness (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

Individual seeking the information's relation to requestee _____

Effective Period

This authorization for release of information covers the period of healthcare from (Choose one).

☐ _____ to _____

OR

☐ all past, present, and future periods.

Extent of Authorization

☐ 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

☐ 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): _____

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.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

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.

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

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.

Please provide any additional details of the accounting of disclosure request.

_____

_____

_____

_____

Please list Restore Medical Fitness staff member that was contacted regarding this matter:

_____ _____

Name of Restore Medical Fitness staff member Date

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative and his/her relationship to the patient Date

(Attach additional documentation, if applicable.) _____ _____

For Administrative Use Only:

Date received

Action taken

Date

HIPAA Compliance Officer Signature

Date