HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I _____have received a copy of the Notice of Privacy Practices from the office of **Gold Naprapathic & Wellness Center, P.C., located at 4305 N. Lincoln Ave., Suite F Chicago, IL 60618.**

1. I hereby authorize **Gold Naprapathic & Wellness P.C.** to use and/or disclose the protected health information described below to _____.
   (Name of Individual)
2. Authorization for Release of Information covering the period of health care of

   A. ☐ All past, present and future records **OR** ☐ _____ to_____.

   B. 1. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

   OR

   2. ☐ I hereby **authorize the release of my complete health record with the exception of the following information:**

   __Alcohol/Drug Abuse Treatment __ Mental Health Records

   __ Communicable Diseases (including HIV and AIDS) __Other_____

3. 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.

4. This authorization shall be in force and effect until I revoke this authorization.

5. 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.

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

7. 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.

8. I authorized Gold Naprapathic to leave appointment reminders or discuss treatment information though the following means:

   a. I do ☐ do NOT ☐ authorize communication to my home phone number.
   b. I do ☐ do NOT ☐ authorize communication to my work phone number.
   c. I do ☐ do NOT ☐ authorize communication to my cell phone number.
   d. I prefer to be reached at the following number _____.

[ ] Patient refuses to acknowledge this notice.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Relationship to Patient**