HIPAA Privacy Authorization Form

Form rev. 4/10/2023

adaptIV infusion

Authorization for Us or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) I authorize AdaptIV Infusion to use and disclose the protected health information described below to my referring physician and any others necessary for coordination of my care.

This **authorization grants permission** to the Contacts named below to (please check all that apply):

☐ Have access to my medical record information and scheduling
☐ Have access to my billing & insurance information

CONTACT INFORMATION

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

This authorization for release of information covers the period of healthcare from (please check one):

☐ till consent is revoked in writing **OR** ☐ till the following date (mm/dd/yy): ____ / ____ / ____

Extent of Authorization (please check one):

☐ I authorize the release of my complete health records (including records relating to mental health, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
☐ I authorize the release of my complete health record except for the following information:
- ☐ Alcohol/drug abuse treatment
- ☐ Mental health records
- ☐ Communicable diseases (incl. HIV & AIDS)
- ☐ 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 claim payment or other purposes as I may direct. This authorization shall be in force and effect unless revoked by the patient or legal representative.

☐ I understand that I have the right to revoke this authorization, in writing, at any time.
☐ I understand that revocation is not effective to the extent that any person or entity has already acted in reliance or on my authorization or if my authorization with 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.

_____ _____

Patient Name (Print) *Patient Signature or Legal Representative Signature*

If Signed by Legal Representative, Relationship to Patient (e.g. parent, spouse, etc):

_____ _____ ____ / ____ / ____

Print Name *Provide Relationship* *Today's Date*