Authorization to Share and Discuss Health Information

For a college-age adult to authorize a family member or caregiver

General HIPAA authorization - complete every required field

Important limitation

This form permits disclosure and discussion; it does not give the recipient authority to make health care decisions. It excludes psychotherapy notes, federally protected substance-use-disorder records, HIV-related information subject to separate authorization, and FERPA-covered school records unless a separate valid authorization is completed.

1. Individual authorizing disclosure

Patient/student name:

Date of birth:

Address:

Telephone or email:

2. Persons or entities authorized to disclose

Any health care provider, hospital, clinic, laboratory, pharmacy, or health plan that maintains information described below about me.

Only the following provider(s) or entity(ies):

3. Recipient authorized to receive information and participate in discussions

Recipient's name:

Relationship:

Address:

Telephone:

Email:

4. Information authorized

I authorize the person(s) or entity(ies) listed in Section 2 to disclose to, and discuss with, the recipient listed in Section 3 the information I select below, including verbal communications reasonably related to that information:

Current condition, diagnosis, treatment plan, and prognosis

Medications, allergies, immunizations, and care instructions

Laboratory, imaging, referral, consultation, and discharge information

Billing, insurance, claims, and payment information

Entire medical record, except the excluded categories listed below

Other:

5. Excluded categories and purpose

This authorization does not include psychotherapy notes; records protected by 42 C.F.R. Part 2 concerning substance-use-disorder treatment; HIV-related information requiring a separate authorization under applicable law; or education and treatment records governed by FERPA, unless I complete a separate authorization that specifically covers the category.

Purpose of disclosure

At my request - to assist with care coordination, communication, insurance, billing, or an emergency.

Other purpose:

Expiration

This authorization must include an expiration date or an expiration event related to me or the purpose of the disclosure.

Expiration date:

Expiration event:

Required statements

- I understand that I may revoke this authorization at any time by giving written notice to any provider or entity relying on it, except to the extent action has already been taken in reliance on it.
- I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan, and eligibility for benefits generally may not be conditioned on signing this authorization, except as permitted by law.
- I understand that information disclosed to a recipient who is not subject to HIPAA may be redisclosed and may no longer be protected by federal privacy rules.
- I understand that I am entitled to a copy of this signed authorization and that a copy, facsimile, or electronically transmitted copy may be relied upon as though it were an original.
- While I have decision-making capacity, this authorization does not permit the recipient to make health care decisions for me.

Signature

Signature of patient/student:

Date:

If signed by a personal representative, print name:

Authority to act for the individual:

Provide a copy to each provider or entity from which disclosure is requested. A campus-operated clinic or counseling center may use a FERPA process instead of HIPAA; complete the school's required authorization as well.

Federal authorization elements: Open official source