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How to Complete Your Pennsylvania HIPAA Authorization

Authorization for Release of Health Information • 45 C.F.R. § 164.508

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This form lets doctors, hospitals and health plans share your medical information with family members or other people you choose. It does not let them make decisions for you; for that, use a Health Care Power of Attorney.

1. **Choose who may release information**
   All of your providers, or only the ones you list.
2. **Name up to three people**
   Each person may receive information separately.
3. **Choose what may be shared**
   Mental health, drug and alcohol, HIV and genetic records are shared only if you initial them.
4. **Set an expiration**
   Write a date or an event. If left blank, it expires two years after signing.
5. **Sign it, and notarize if needed**
   Some insurers and out-of-state providers ask for a notarized authorization.

Signing requirements: Signed by the patient or a personal representative. Notarization is optional but often requested by insurers and institutions.

After It's Signed

- Give copies to each provider and to the people you named. Keep the original.

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Have questions about your HIPAA Authorization? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Pennsylvania • 45 C.F.R. § 164.508

1. PATIENT

Patient full name

Date of birth

Address

Phone

2. WHO MAY RELEASE INFORMATION

☐ Any doctor, hospital, clinic, laboratory, pharmacy, health plan or other covered entity that has provided me treatment or services or paid for my care.

☐ Only the following provider(s):

3. WHO MAY RECEIVE INFORMATION

I authorize the release of my health information to each of the following persons, who may act separately:

Person 1 name | Relationship | Phone

Person 2 name | Relationship | Phone

Person 3 name | Relationship | Phone

4. INFORMATION TO BE RELEASED (check one)

☐ All of my health information, including medical records, test results, billing records, and information about my diagnosis, treatment and prognosis.

☐ Only the following information:

Specially protected information. Federal and Pennsylvania law give extra protection to certain records. They are included **only** if I initial below:

_____ Mental health treatment records (not including psychotherapy notes, which require a separate authorization).

_____ Drug and alcohol abuse treatment records.

_____ HIV-related information and test results.

_____ Genetic testing information.

5. PURPOSE

At my request, to allow the persons named above to communicate with my providers and to help with my care, payment and personal affairs.

6. EXPIRATION

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This authorization expires on (date or event). If blank, it expires two years from signing.

7. MY RIGHTS

I may revoke this authorization at any time by giving written notice to the provider holding my information, except to the extent the provider has already acted in reliance on it. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. Information released under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy rules. I am entitled to a copy of this authorization. A photocopy or electronic copy is as valid as the original.

X _____

Patient signature (or personal representative) | Date

If signed by a personal representative: name and authority (e.g., agent under health care POA, guardian, parent)

NOTARIZATION (OPTIONAL, OFTEN REQUESTED)

ACKNOWLEDGMENT

COMMONWEALTH OF PENNSYLVANIA

COUNTY OF _____

This record was acknowledged before me on _____ (date) by _____ (name(s) of individual(s)).

X _____

Signature of notarial officer

Title of office (e.g., Notary Public)

My commission expires | Commission number

(Notary seal)

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