HIPAA Privacy Authorization Form

I authorize Blossom Wellness Center to use and disclose the Protected Healthcare Information (PHI) described below to the following individuals:

Full Name: ____ Relationship: _________________________

Full Name: ____ Relationship: _________________________

Full Name: ____ Relationship: _________________________

Full Name: ____ Relationship: _________________________

Full Name: ____ Relationship: _________________________

Effective Period: This authorization for release of PHI covers the following period of time: (please circle one option)

A. From _______________ to _______________
B. All past, present and future periods

Extent of Authorization: (please circle one option)

A. 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)
B. I authorize the release of my complete health record with the exception of the following information:
   - Mental health records
   - Communicable disease (HIV and AIDS)
   - Alcohol/Drug Abuse treatment
   - Other (please specify) ____

I understand that I have the right to revoke this authorization, in writing, at any time.

Patient Name (printed): ____

Patient Signature: ____

Date: ____

Best way to contact you: ____

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