HIPPA Authorization Form: Release of Patient Information

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Aspen Family Medicine & Geriatrics to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give yourauthorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Patient's Full Legal Name: _____ Date of Birth: _____ Sex: M ☐ F ☐

Mailing Address: _____ City: _____ State/Zip:_____

Home Phone: ( ) _____ Mobile: ( ) _____ Work Phone:( ) _____

I, _____ hereby authorize Aspen Family Medicine & Geriatrics and/or any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

1. _____
   Name Phone Relation to patient
2. _____
   Name Phone Relation to patient
3. _____
   Name Phone Relation to patient

☐ I authorize Aspen Family Medicine & Geriatrics or the medical facility to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

☐ I authorize Aspen Family Medicine & Geriatrics to release my prescription(s) for controlled substances to the above individuals. I understand that I may revoke/modify individuals above or cancel this authorization by submitting written notification to Aspen Family Medicine & Geriatrics.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. The notice describes the types of usage and disclosure of my protected health information (PHI) that might occur in my treatment, payment of my bills or in the performance of health care operations. This form will be filed in the patient's medical record.

I,_____ have received a copy of this office's Notice of Privacy Practices from Aspen Family Medicine & Geriatrics

Patient Signature _____ **Date**_____

***FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ It was emergency treatment ☐ Inability to communicate with patient ☐ Patient refused to sign

☐ Patient unable to sign Reason: _____ ☐ Other (Please Specify):_____