



HIPAA Representative Form

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the HIPAA Representative named below to have authority to access to my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below:

Patient Information – Please Print

HIPAA Representative Information - Please Print

Patient Name: _____ Date of Birth: _____
Address: _____ City/State/Zip Code: _____ Telephone
most easily reached: _____
Name: _____ Date of Birth: _____
Address: _____ City/State/Zip Code: _____
Telephone # most easily reached: _____
Relationship to Patient: _____

I grant to the HIPAA Representative named above access to:

- ___ All of my PHI – note separate box below is also required for HIV, psychiatric and substance abuse access.
- ___ Other - Specify limits or specific health care incident: _____

By checking the appropriate categories and by signing this box I (patient) am granting my HIPAA Representative access to additional health information:

I understand that the information in my medical record may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representative access to information relating to: (you must initial each area you wish the HIPAA Representative to have access to)

- ___ Alcohol, drug, or substance abuse information
- ___ AIDS, HIV-related information (including AIDS related testing and results)
- ___ Mental Health
- ___ Sexually Transmitted Disease information
- ___ Genetic information
- ___ Research Information

The confidentiality of this record is required under New York State and Federal Law. This material shall not be transmitted to anyone without written consent or authorization.

Signature of Patient for this box: _____ **Date:** _____

I understand that I may revoke this HIPAA Representative designation at any time by notifying the Director of Health Information writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by All Med Physicians prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be re-disclosed by the recipient and no longer protected by HIPAA.

4. I understand that this Authorization will: (Must check one)

expire 1 year from the date executed: or

be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient: _____ Date: _____

Signature of HIPAA Representative: _____ Date: _____

(Form will not be valid unless all appropriate blanks are filled)

YOU MAY REFUSE TO SIGN THIS FORM