HIPAA Privacy Authorization Form

Path To Wellness Acupuncture, Dr. Maureen McKenney

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164)

1. I authorize Dr. Maureen McKenney to use and disclose the protected health information described below to ____.
2. This authorization for release of information covers the period of healthcare for all past, present and future periods. _____ Yes _____ No, only dates ____.
3. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV/AIDS and treatments of alcohol or drug abuse). ____ Yes ____ No, I authorize the release of my complete health records with the exceptions of ____.
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.
5. This authorization shall be in force and in effect until __________________, at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revoking this authorization is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
9. By signing below, **I authorize that I have read the privacy policies listed on the Path to Wellness website or have requested and read a hard copy and understand and agree to all clauses in this policy**. I also understand and agree to all clauses of this privacy form.
10. By signing below, I authorize the staff of Path to Wellness to leave a message on my primary phone number listed below regarding my appointment, my medical care/results, my patient account/billing and any information I request.

____

Primary phone number of patient

____

Signature of patient or patient representative

____

Printed name of patient or patient representative and his/her relationship to patient

____

Date