Midori Med

HIPAA Privacy Authorization Form

I authorize Center for Midori Med to use and disclose the protected health information described below to

_____ (individual seeking the information).

A. This authorization for release of information covers the period of healthcare from _____ to

_____

OR

B. All past, present, and future periods.

_____ ** AND ** _____

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).

OR

B. I authorize the release of my complete health record with the EXCEPTION of the following information:
Mental health records
Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment
Other (please specify): _____

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.

I understand that I may refuse to sign this authorization and that it is strictly voluntary. I may revoke this authorization by notifying the above person or entity in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that I may see and obtain a copy of my medical records from CNTR for any reasonable fee if I request it. I have read the above and authorize the disclosure of my protected health information as stated. A copy of this authorization should be retained by the patient. This authorization automatically expires 12 months from the date signed.

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.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient