HIPAA Authorization

KloudScript

Specialty Care *Redefined*

HIPAA Regulations require this Facility to obtain an authorization for certain disclosure. Please read and sign the below, if you wish to approve this authorization.

I understand that if I refuse to sign this Authorization, it will not affect my ability to receive treatment, payment or eligibility of benefits, except in the following:

- The treatment is research-related
- Enrollment into a health plan, if to determine eligibility and it is not for uses or disclosure of psychotherapy notes
- The sole purpose of the treatment is to create Protected Health Information that will be disclosed to a third-party

If the recipient is not covered by the HIPAA Regulations, then the information disclosed may not be further protected.

Sign and date below to acknowledge that you are accepting this Authorization of Use and/or Disclosure	
Patient/Personal Representative Signature	Date
Printed Name if Not the Patient	Relationship

You may revoke this Authorization at any time in writing by sending a written notification to the Facility or you may complete the revocation notice below and return it to the Facility.

By completing the below, I request that this Authorization be Revoked. I understand that this revocation will not apply to any uses or disclosures that have already occurred.	
☐ I am requesting the revocation of this Authorization	
Patient/Personal Representative Signature	Date
Printed Name if Not the Patient	Relationship