Carolina Family Healthcare

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HIPAA PRIVACY AUTHORIZATION FORM

** Required by the Health Insurance Portability & Accountability Act, 45 C.F.R.

I authorize Carolina Family Healthcare to use and disclose the protected information described below to

_____

(individual seeking information).

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

EXCLUDE:

____ Mental health record

____ Communicable disease (HIV, STD)

____ Other (please specify): _____

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

I understand that I have the right to revoke this authorization, in writing, at any time.

_____

Signature of patient or personal representative

_____

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

_____

Date

www.CarolinaFamilyHealthcare.com

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