[Dr. Darla L Logan (CellMed Clinics) **HIPAA AUTHORIZATION**
FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

7950 E Acoma Dr #207 Scottsdale AZ 85260

CellMed Clinics provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information.

☐ All of my health information

☐ My health information relating to the following treatment or condition:
_____

☐ My health information covering the period of healthcare from (date) _____ to (date)_____

☐ Other:_____

The above party may disclose this health information to the following recipient:

Name (or title) and organization_____

Address _____

City _____State _____Zip_____

Phone _____Fax _____Email_____

The purpose of this authorization is (check all that apply):

☐ At my request

☐ Other: _____

☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

☐ On (date)_____

☐ When the following event occurs:_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.
I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age

☐ Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____