# HIPAA Privacy Authorization Form

**Effective Date**: June 7, 2021

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

**1. Authorization**. I authorize Highlands Foot & Ankle, LLC (health care provider) to use and disclose the protected health information described below to an individual with the requesting party being related to the Patient by blood (to the best of our knowledge) as their (individual seeking the information).

**2. Effective Period**. This authorization for release of information covers all past, present, and future periods of health care.

**3. Extent of Authorization**. I authorize the release of my financial & complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**4. Use**. 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. Termination**. This authorization shall be in force and effect until the death of the Patient, at which time this authorization form expires except for final balance payment as insurance can take several months.

**6. Revocation Rights**. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation 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. Benefits**. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**8. Disclosure**. 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. Email**: I authorize Highlands Foot & Ankle, LLC to send my information to the family member below via email. HIPAA-compliant email and attachments

**10. Texting and Email Communication Terms:** Consent and Opt-In: By providing your phone number or email address to our practice through this website or direct communications with our office, you consent to receive text messages and emails from our firm. You can opt-out at any time by replying "STOP" to text messages or clicking/responding "UNSUBSCRIBE" in emails. Frequency: We will only send relevant messages related to our products, services or updates. We respect your privacy and will not spam you. Refer to our privacy policy posted on this website in the "About Us" Section. Message Charges: Standard message and data rates may apply for text messages. Email communication is free. Content: Our messages will include important updates, inquiries, questions or other relevant information. If you have questions, reply to our texts or emails. Disclaimer: Our general messages are for informational purposes only.

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# HIPAA Privacy Authorization Form Continued

**Patient's Signature** (or Power of attorney-must provide notarized proof):

Patient Name

Patients Signature_____

Date: _____

**Name & Signature of Family member** we are releasing information to:

Receivers Name: Signature:_____

Date: _____ Email: _____@ _____.com

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