HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Us or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)
I authorize Sage Infusion LLC to use and disclose the protected health information described below to my referring physician and any others necessary for coordination of my care.
This authorization for release of information covers the period of healthcare from (**please check one**):

☐ till consent is revoked in writing **OR** ☐ till the following date (mm/dd/yy): _____

Extent of Authorization (**please check one**):

☐ I authorize the release of my complete health records (including records relating to mental health, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record except for the following information:

- o Mental health records
- o Communicable diseases (incl. HIV & AIDS)
- o Alcohol/drug abuse treatment
- o 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 claim payment or other purposes as I may direct. This authorization shall be in force and effect unless revoked by the patient or legal representative.

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that revocation is not effective to the extent that any person or entity has already acted in reliance or on my authorization or if my authorization with obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- 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.

EMERGENCY CONTACT INFORMATION

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

This authorization grants permission to the Emergency Contacts named above to (**please check all that apply**):

☐ Have access to my medical record information and scheduling

☐ Have access to my billing & insurance information

Patient Name (Print):_____ **X** _____
Patient Signature or Legal Representative Signature

If Signed by Legal Representative, Relationship to Patient (e.g. parent, spouse, etc):

_____ _____
(Print Name and Provide Relationship) Today's Date