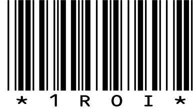
GRITMAN
MEDICAL CENTER

700 South Main Street
Moscow, ID 83843
(208) 882-4511



HIPAA AUTHORIZATION FORM
Authorization for the Use and Disclosure of Protected Health Information

I, ______________________________________, give permission to Gritman Medical Center to:
□ use the following protected health information, and/or
□ disclose the following protected health information to:

____

____
[Name(s) of entity to receive information]

Information to be disclosed (check all that apply):
□ Medical Records □ Treatment Records □ Diagnostic Records □ Billing/Payment Information
□ Other:____

____

This protected health information is being used or disclosed for the following purposes:

□ Continuity of Care □ Participation of Support System

□ Other ____

____

This authorization expires [specify (1) date or (2) event that relates to the purpose of

this use or disclosure].____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization.

You may revoke this authorization in writing at any time by sending written notification to Privacy Officer at Gritman Medical Center, 700 South Main St., Moscow, ID 83843. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____
Signature of Patient or Personal Representative

____
Date

____
Printed Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

HIPAA Authorization Form

Patient Demographics

Name________________________________

Birthdate: ___________________________

Address or Phone _____________________

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