



## HIPPA PRIVACY AUTHORIZATION FORM

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

1. Authorization  
I authorize Concierge MD LA to receive and use my protected health information
2. Effective Period  
This authorization for release of information covers the period of healthcare from for all past, present, and future periods.
3. Extent of Authorization
  - a. 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).
4. 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. This authorization shall be in force while I am under the medical care of Concierge MD LA or in the event that I otherwise authorize disclosure of my medical information.
6. 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. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. 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.