Foster City Medical Center
Primary Care and Urgent Care

HIPAA PRIVACY AUTHORIZATION

THIS AUTHORIZATION IS FOR MEDICAL INFORMATION ABOUT YOU THAT MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I,_____, authorize Foster City Medical Center to use and disclose the protected health information described below.

This authorization for release of information is from:

□ **ALL** past, present, and future periods.

-OR-

□ Covers the period from _____ to _____.

EFFECTIVE PERIOD:

□ I authorize the release of my complete health record. This will include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

-OR-

□ I authorize the release of my complete health record with the **exception** of the following information:

□ Communicable diseases (including HIV and AIDS)

□ Mental health records

□ Alcohol/drug abuse treatment

□ Other (please specify):_____

(This authorization is required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Please read thoroughly and **initial** the following statements as agreed:

_____ *I understand that my treatment, payment, eligibility or enrollment for benefits will not be conditioned on whether I sign this authorization.*

_____ *This medical information may be used by Foster City Medical Center to receive this information for medical treatment or consultation, claims payment/billing, or other purposes.*

_____ *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.*

_____ *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.*

YOUR RIGHTS

●You have the right to obtain a paper copy of this notice from us, *upon request*.
●You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
●You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.
●You have the right to inspect and copy your Protected Health Information.
●You have the right to request a restriction of your Protected Health Information.
●You may have the right to have your physician amend your Protected Health Information.

_____ _____

Patient Signature or Signature of representative **Date**

_____

Printed Name of Patient or representative

_____

Relationship to patient if representative

(This authorization is required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)