

**BLUE SKY HEALTH AND WELLNESS**  
HIPPA Privacy Authorization Form

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

I authorize Dr Jennifer Sims, D.C. to speak and disclose the protected health information described below to \_\_\_\_\_ (individual seeking the information).

**2. Effective Period**

This authorization for release of information covers the period of healthcare from:

- a.  \_\_\_\_\_ to \_\_\_\_\_.
- b.  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).
- b.  I authorize the release of my complete health record with the exception of the following information:
  - Mental health records
  - Communicable diseases (including HIV and AIDS)
  - Alcohol/drug abuse treatment
  - Other (please specify): \_\_\_\_\_

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 and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

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.

\_\_\_\_\_  
Patient Signature/ or Guardian

\_\_\_\_\_  
Printed Name of Patient/ Guardian

Date: \_\_\_\_\_