HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization:** I authorize Mt. Hood Senior Solutions, LLC to use and disclose the protected health information described below to prospective housing communities that would be appropriate options for me to move into.
2. **Effective Period:** This authorization for release of information covers healthcare information from all Past, Present and Future periods.
3. **Extent of Authorization:** I Authorize the release of my complete heath record with the exception of the following information:

   *Mental health records, Communicable diseases (including HIV and Aids) Alcohol/drug and use 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 I terminate my agreement with Mt. Hood Senior Solutions, LLC that any 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 weather 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.

_____

Signature of patient or personal representative

_____

Printed name of patient or legal representative and their relationship to patient Date