



Infusion Therapy Services  
Specialty Mobility Services  
Home Medical Equipment  
Respiratory Services  
Retail Store Front

# HIPAA Privacy Authorization Request Form

This form may be filled out by a patient or patient’s personal representative and returned to HME Specialists to authorize use and disclosure of protected health information to designated parties other than the patient. **In order for this form to be approved all fields are required.**

### 1. Authorization:

I authorize HME Specialists to use and disclose the protected health information described below to the following individual(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 2. Effective Period:

This authorization for release of Protected Health Information is valid for dates of service during the following length of time:

From \_\_\_\_\_ to \_\_\_\_\_

### 3. Extent of Authorization: (checkmark box next to appropriate option)

- I authorize the release of my complete health record to include all diagnosis, treatment and payment information for the above time period.
- I authorize the release of any information as it would relate to diagnosis and treatment, but excluding all billing information.
- I authorize the release of any information as it would relate to payment and billing inquiries only, not to include diagnosis or treatment related services.
- Other (Please specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 4. Expiration:

This authorization shall be in force from the date reviewed until \_\_\_\_\_ (date or event), at which time this authorization will expire.



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5. This medical information may be used by the person I authorize to receive this information for medical treatment, consultation, billing, claims payment or any other purposes that I may direct.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that this revocation will not be in effect until HME Specialists received this notice and processes the request in my account.
7. I understand that my treatment, payment, or eligibility to receive services from HME Specialists will not be conditioned on whether or not that 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.

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Signature of patient or patient's personal representative

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Printed name of patient or patient's personal representative

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If signed by patient's personal representative please state your relation to the patient

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Date

HME Specialists  
3901 Masthead St.  
Albuquerque, NM 87109  
Phone: 505-888-6500  
Fax: 505-888-6505  
compliance@hmespecialists.com

Please print below the patient's name and date of birth, or the patient's ID number:

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