# HIPAA Privacy Authorization Request Form

Patients or their legal representatives can complete this form and return it to HME Specialists (HMES) to authorize the disclosure of protected health information (PHI) to designated parties other than the patient. All fields must be completed for the form to be approved.

1. **Authorization:** I authorize HMES to use and disclose my PHI described below to the following individual(s).

**Name:** _____ **Relationship:** ☐ Spouse ☐ Son/Daughter ☐ Other

**Name:** _____ **Relationship:** ☐ Spouse ☐ Son/Daughter ☐ Other

**Name:** _____ **Relationship:** ☐ Spouse ☐ Son/Daughter ☐ Other

2. **Effective Period:** This authorization to release my PHI, is applicable for dates of service during the following timeframe. *(**Use dates only** - mm/dd/yyyy. Do not use terms like: forever, always, unlimited, etc.)*

**From Date:** ___/___/___ **To Date:** ___/___/___

3. **Extent of Authorization:** (Check the box next to the desired/applicable option.)

☐ I authorize the release of my **complete health record** to include all diagnosis, treatment, payment, and billing information for the above effective period (#2, above).

☐ I authorize the release of any information as it relates to my **diagnosis and treatment**, but exclude billing information.

☐ I authorize the release of any information as it relates to **payment and billing inquiries**, but exclude diagnosis or treatment-related services information.

☐ Other (please be specific): _____

what is this for _____

4. This authorization will remain valid from the date reviewed/approved by HMES until the specified date/event, after which it will expire as indicated above (#2).
5. This medical information may be used by the person(s) I authorize to receive this information for medical treatment, consultation, billing, claims payment, and/or any other purpose that I may direct, as indicated above.
6. I understand that I have the right to revoke this authorization, in writing and at any time. I understand that this revocation will not be in effect until HMES receives this notice and processes the request in my account.
7. I understand that my treatment, payment, or eligibility to receive services from HMES will not be conditioned on whether (or not) I sign this authorization.
8. I understand that information used or disclosed under this authorization may lose federal and/or state law protection once received by the recipient.

**Patient Name *(PRINTED)*** _____ **Patient's Date of Birth or HMES ID Number** _____

**Patient Signature** _____ **Patient Signature Date** _____

***Patient Personal Representative** – *Complete this section if the patient is legally incapacitated or otherwise unable to provide authorization for the disclosure of their PHI **and** provide relevant legal or court documents authorizing disclosure of their PHI, as required by applicable state and federal laws, including but not limited to HIPAA regulations.*

**Patient's Personal Representative's Name *(PRINTED)*** _____ **Relationship to Patient** _____

**Patient's Personal Representative's Signature** _____ **Signature Date** _____

**Email this completed form to *Compliance@hmespecialists.com* or send it via mail/fax using the information below.**

3901 Masthead Street, NE, Albuquerque, NM 87109 Ph: 505.888.6500 Fax: 505.888.6505 www.hmespecialists.com