HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Patient Name:_____

DOB:_____

OMI Account #:_____

1. I hereby authorize OMI Diagnostics to use and/or disclose protected healthcare information protected health information described below to _____.

2. Authorization for Release of Information. Covering the period of health care from

☐ _____ to _____ OR ☐ all past, present and future periods:

a. ☐ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
OR

b. ☐ I hereby 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): _____

3. 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.

4. This authorization shall be in force and effect until 2020 , at which time this authorization expires.
5. 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.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. 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 **Date**

$50.00 fee for medical records retrieval

Please mail completed form and payment to: P.O. Box 800065

Roswell, GA 30075

BEFORE YOU MAIL THIS CONSENT, PLEASE MAKE SURE THE FOLLOWING ITEMS ARE ENCLOSED:

- **HIPPA consent is properly completed and signed**
- **Check for $50.00 made payable to OMI Diagnostics is enclosed**

Contact Number: 678-691-2756

Fax Number: 888-802-8664

Contact Email: medicalrecords@omidiagnostics.com