Integrity Administrators
1787 Tribute Rd, Ste E
Sacramento, CA 95815
(916) 921-3388

HIPAA Authorization for Release of Information

I, ____, hereby authorize Integrity Administrators to (check those that apply):

☐ Use the following protected health information, and/or
☐ Disclose the following protected health information to ____________________________:

____

____

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

This protected health information is being used or disclosed for the following purposes:

____

____

[List specific purposes here.]

This authorization shall be in force and effect until ____ (specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Kathy Franklin, Privacy Officer_ at Integrity Administrators. I understand that a revocation is not effective to the extent that Integrity Administrators has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Integrity Administrators_ will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to the [Integrity Administrators_from a third party.] [If applicable.]

______________________________	______________________________
Name of Patient or Personal Representative	Signature of Patient or Personal Representative
______________________	______________________________
Date	Description of Personal Representative's Authority

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