Novus Behavioral Health
556 Fire Station Road, Suite A
Clarksville, Tennessee, US - 37043-4071

HIPAA Privacy Authorization

HIPAA 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 the following health care professional to use and disclose the protected health information described below to Novus Behavioral Health.

Previous Provider (from): _____

2. Effective Period: This authorization for release of information covers the period of healthcare from:

Dates of care: _____

3. Extent of Authorization: I authorize the release of my complete health record (including records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

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 date entered, at which time this authorization expires.

One year period from date of signing: * _____

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 entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage & 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 whether 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.

Name: * _____

DOB: * _____

PATIENT SIGNATURE * _____

Date: * _____