HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected health Information as required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. Authorization
    a. I authorize Sequoia Integrative Medical Services, LLC and their providers, to use and disclose the protective health information described below to insurance companies, other medical providers, anyone involved in my care or billing company.

2. Effective Period
    a. This authorization for release of information covers the period of healthcare from
        i. _____ to _____

    OR

        ii. All past, present, and future periods.
        PREFERRED This allows Sequoia Integrative Medical Services, LLC to access all needed medical documents throughout the entire service period of the patient.

3. Extent of Authorization
    a. I authorize the release of my complete and health record, including records relating to medical healthcare,communicable diseases, HIV or AIDS, and treatment of alcohol and drug abuse, or any other treatments (please specify).

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 purposes as I may direct.
5. This authorization shall be in effect for duration of patients care.
6. I understand that I have the right to revoke this authorization, in writing, at anytime. 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.
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.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative/Relationship Date