HIPPA PRIVACY AUTHORIZATION FORM

****Authorization for Use or Disclosure of Protected Health Information****

1. **I authorize, Promise Pathway and its subsidiaries to use and disclose the protected health information described below to** Click or tap here to enter text.

2. **This authorization for release of information covers the period of healthcare from** Click or tap to enter a date. **to** Click or tap to enter a date.

   OR

   □All Past, Present, and Future periods.

3. **Extent of Authorization**

   □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV/AIDS, Substance/Alcohol Use.

   OR

   □ I authorize release of only the following information (such as mental health, substance use, etc.)
   Click or tap here to enter text.

4. **This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.**

   Click or tap here to enter text.

Name: Signature **Date:** MM/DD/YYYY