HIPAA Authorization Form
(DISCLOSURE OF HEALTH INFORMATION)

HIPAA AUTHORIZATION - This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. By completing and signing this form, I, or my legal representative, agree to allow JHS Community to share my protected health information (PHI) with the person(s) and/or organization(s) listed below. I understand this authorization is voluntary, and I hereby give permission to disclose my personal health information (PHI) as described below.

NAME OF MEMBER OR INDIVIDUAL

FIRST NAME:	LAST NAME:
DATE OF BIRTH:	MEMBER ID#:

Authorization Statement:
I hereby authorize the disclosure of my Protected Health Information to the individuals named below. I understand this authorization is voluntary and that refusal to sign will not affect my ability to obtain and retain membership.

AUTHORIZED PARTIES AND RELATIONSHIP

1) FULL NAME:	RELATIONSHIP:
PHONE:	EMAIL:
2) FULL NAME:	RELATIONSHIP:
PHONE:	EMAIL:

Please Select *One* of the Following Options:

I allow the above-mentioned person(s) to receive information related to (please select one):

☐ **Disclose my complete health record(s)**
(including but not limited to diagnosis, labs, tests, treatments, and billing for all medical conditions)

OR

☐ **Only disclose and/or allow changes to the portions of my health record listed below (check all that apply):**

- ☐ **Billing, Membership, and or Update Records**
- ☐ **Communicable Diseases, HIV / AIDS**
- ☐ **Alcohol / Drug Abuse Treatment**
- ☐ **Physical or Sexual Abuse**
- ☐ **Mental Health Treatment**
- ☐ **Abortion and or services**
- ☐ **Other (please list):** _____

This Authorization Ends: (Select One)

☐ **Shall be effective until** _____ **(date) unless cancelled prior**

☐ **When the following event occurs:** _____

☐ **If 2 fields above are left blank, authorization expires 1 year from the date of signature on next page**

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My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission.

TO REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING, AND I UNDERSTAND I MUST SEND IT TO THE APPROPRIATE DISCLOSING PARTY.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person(s) or organization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signatures and Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1).

Signature of Patient / Member: _____

Date Signed: _____

Complete this section ONLY if patient is a minor or unable to sign:

- ☐ **Patient is a minor:** _____ **years of age**
- ☐ **Patient is unable to sign because:** _____

Authority of Representative to Sign on Behalf of Patient:

☐ **Parent** ☐ **Legal Guardian** ☐ **Court Order** ☐ **Enrolling Producer** ☐ **Other:** _____

Authorized Representative Name: _____

Authorized Representative Signature: _____

Date Signed: _____

Disclaimer: JHS Community is a 501(c)(3) non-profit Health Care Sharing Ministry (HCSM). The members of JHS Community voluntarily share in one another's eligible medical needs based on the acceptance of our Information Guide (IG). All members accept responsibility for their own medical needs as JHS Community is not an insurance company and is not regulated as insurance. Any program offered from JHS Community should not be considered a substitute for an insurance policy. JHS Community nor any member of JHS Community assume any legal obligation to share in the eligible medical needs incurred by any other JHS Community member.