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## 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 \_\_\_\_\_ (healthcare provider) to use and disclose the protected health information described below to \_\_\_\_\_ (individual seeking the information- provide name, address, and phone number).

### 2. Effective Period

This authorization for release of information covers the period of healthcare from:

- a.  \_\_\_\_\_ to \_\_\_\_\_. \*\*OR\*\* b.  all past, present, and future periods.

### 3. Extent of Authorization

- a.  I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).  
\*\*OR\*\*
- b.  I authorize the release of my complete health record with the exception of the following information:
- Mental health records
  - Communicable diseases (including HIV and AIDS)
  - Alcohol/drug abuse treatment
  - Other (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 other purposes as I may direct.

5. Unless cancelled in writing earlier, this authorization shall be in force and effect until termination of treatment with Dr. Benzl. Alternatively, I may provide an expiration date for this authorization here: \_\_\_\_\_

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 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.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_