LAW OFFICE OF KG, PLLC
www.lawofficeofkg.com

KLEINHANS GRUBER
701 Brazos St., Ste. 500
Austin, Texas 78701
T: 512.961.8512
F: 888.336.3069

HIPAA Privacy Authorization Form For Law Office of KG, PLLC

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164). Clients, please fill in the blanks. Providers, please contact Kimberly A. Gruber, Keith L. Kleinhans, or one of our assistants with any questions at 512.961.8512

1. I hereby authorize to use and/or disclose __________[Name of Health Care Provider]_____________the protected health information described below t0: ***Law Office of KG, PLLC, 701 Brazos Street, Ste. 500, Austin, TX 78701, 512.961.8512, kg@lawofficeofkg.com.***

2. Authorization for Release of Information:

   Covering the period of health care from _____________ [Date of Incident]_____ to __________________.

3. 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.

4. This authorization shall be in force and effect until ***one year*** *from the date that this HIPAA was signed*, at which time this authorization expires.

5. 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.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. 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.

______________________________________ ______________________________

Social Security Number of Patient **Patient Date of Birth**

____ _______________

Signature of Patient or Personal Representative **Date**

____

Print Name of Patient or Personal Representative Relationship to Patient