



HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

I _____ hereby authorize The National Organization for Rare Disorders
(PRINT PATIENT NAME)

(“NORD”) to use and/or disclose my Protected Health Information (“PHI”) described below:

I hereby authorize the release of PHI as follows (**check one**):

a. My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse).

OR

b. My complete health record with the exception of the following information (check as appropriate):

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

In addition to the authorization for release of my PHI described above, I authorize the release or disclosure of any information or PHI in connection with any claim or appeal for coverage or benefits, including but not limited to benefits, premiums, eligibility, deductibles, claims payment, etc.

I hereby authorize NORD to discuss and receive copies of my PHI (e.g., explanation of benefits, etc.) as necessary to determine eligibility for assistance through the NORD Patient Assistance Program.

This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

I understand that:

- I have the right to revoke this authorization, in writing, at any time;
- This revocation is not effective if a person or entity has already acted in reliance on my authorization or if an insurer relied on this authorization to provide coverage;
- Information used or disclosed pursuant to this Authorization may be disclosed by the Authorized Person(s) and may thus not be subject to federal/state privacy laws.

Signature of Patient Date: _____

Signature of Parent/Guardian Date: _____