Appendix N

Release of Information (HIPAA Privacy Authorization Form)

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

Authorization for use or disclosure of protected health information (required by the Health Insurance Portability and Accountability Act, 45 CFR, Parts 160 and 164)

1. I authorize _____ (healthcare provider) to disclose the protected health information described here to Kristin Yeoman, MD.
   _____
   _____
2. Effect period _____ to _____ (authorization for release of information covers this period)
3. Use. This medical information may be used to determine eligibility for NIOSH/CDC study.
4. Termination. This authorization shall be in force and effect until _____, at which time this authorization form expires.
5. Revocation rights. 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.

Patient signature _____

Printed name _____

Date _____