

Appendix N

Release of Information (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)

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 _____

CDC estimates the average public reporting burden for this collection of information as 1 minute per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-_____)