KEYSTONE ADVANCED THERAPIES
2208 QUARRY DRIVE, SUITE 200
WEST LAWN, PA 19609
TELEPHONE (610)396-5139 or (610)334-8131 (text line)
FAX: (484)509-5141

# 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)

I authorize Dr. Scot M. DePue and Keystone Advanced Therapies to use and disclose the protected health information described below to the following individual(s):

_____

Effective Period:

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

Extent of Authorization:

_____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.

_____I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental Health records
- ☐ Communicable Diseases
- ☐ Alcohol / Drug treatment
- ☐ Other (please specify): _____

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 any other purposes as I may direct.

This authorization shall be in force and effective until _____at which time this authorization expires.

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.

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

I understand that information used or disclosed pursuant to this authorization may be disclosed and may no longer be protected by federal, state or local law.

_____

(signature of patient or personal representative)

_____

(printed name of patient or representative and relationship)

Date: _____/_____/_____