IUPUI
CAMPUS HEALTH

Communication Authorization

HIPAA (Health Insurance Portability and Accountability Act) is a federal law that protects the privacy of your medical information. HIPAA limits who your health care providers can share your medical information with unless you give your permission in writing by filling out a Communication Authorization form.

It is the policy of IUPUI Campus Health, not to release confidential medical information regarding your treatment to anyone except for (i) parent/legal guardian (if under 18 years of age), (ii) persons authorized by the patient, (iii) anyone we may reasonably infer from the circumstances such as having anyone in the exam room with you, we will assume, unless you verbally object, that the person is entitles to receive information regarding your treatment, (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The written copy of the full HIPAA law is available upon your request.

If you want your medical information to be provided to anyone, please indicate below, so that we may best serve your wishes. By signing this document, you authorize the following persons to receive information, as requested, regarding your care and treatment.

Name	Relationship to you	Telephone Number
_____	_____	_____
_____	_____	_____

I understand I have the right to revoke this consent at any time. To revoke this authorization, you must do so in writing and deliver the document to IUPUI CH. Alternatively, complete the Revoke Communication Authorize form and return to the IUPUI CH.

This consent is valid for a 12-month period and must be updated annually.

_____	_____	_____	_____
Patient Signature	Print Name	Date of Birth	Date