**HIPAA Authorization Form**

**The HIPAA Privacy Rule** (**Health Insurance Portability and Accountability Act of 1996)** provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

***Only complete this form if*** ***your family meets the definition of an “Elderly” or “Disabled” household under the Housing Choice Voucher Program:***

**“Elderly Household”** is defined as the Head, Spouse or Co-head is at least 62 years of age or older.

**“Disabled Household”** is defined as the Head, Spouse or Co-head is a person with disabilities.

If your household meets one, or both, of these definitions then **ALL members in your household** will qualify for the medical

**I hereby authorize** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release

 (Name and Address of Medical Provider)

my protected health information to:

**MaineHousing, 26 Edison Drive, Augusta, Maine 04330, Attention: Housing Choice Voucher Department**.

**INFORMATION TO RELEASE** The specific health information I do authorize to release to MaineHousing is:

**\_\_\_\_\_**Medical expenses over the past 12 months, payment plans or ongoing costs.

***Please initial:***

**\_\_\_\_\_** If the medical condition or coverage is likely to continue during the next 12 months.

**\_\_\_\_\_** If a private bedroom or special feature of a unit is required due to medical reason(s).

\_\_\_\_\_ Verification of Disability Status

**Do Not Share** any descriptions, details or disclosure of medical conditions, diseases, treatments, services, benefits, or claims with MaineHousing.

**PURPOSE OF AUTHORIZATION TO RELEASE:**

To determine medical deductions offered for the Housing Choice Voucher Program.

**EFFECTIVE PERIOD OF AUTHORIZATION:**

This authorization for release of information will end one year from the signature below,

**I UNDERSTAND** I do not have to sign this authorization to release information and that I can cancel this authorization, in writing, at any time. I understand that any action that has already been taken based on this authorization cannot be reversed, and my cancellation will not affect those actions. I understand that my treatment, payment, enrollment or eligibility for benefits will not depend on whether I sign this authorization. I understand the authorized information may be disclosed by the MaineHousing and may no longer be protected by federal or state law. I understand a copy of this authorization is available to me, or my authorized representative, upon request and will serve as the original.

**SIGNATURES: Head of Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

(Printed Name) (Signature) (Date)

 **Person this information is about:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

(Printed Name) (Signature) (Date)

***Or, if applicable:* Parent, Personal Representative or Guardian:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

(Printed Name) (Signature) (Date)

 **Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Please state your **relationship to** the person this information is about).