Consent to Disclose Personal Health Information
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, _____(Print your name) authorize _____

_____

(Print name of health information custodian and title) whose address is _____

_____

to disclose the protected health information described below to **The Clerical Council for Family Affairs – Americas District also known as CCFFAA and/or its assigned representatives, P.O. BOX 419, Cedar Grove, NJ 07009**

1. ☐ I hereby authorize the release of (check one box only) ☐ my or ☐ my dependents _____ (*Print name of dependents)* complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
2. ☐ I hereby authorize the release of (check one box only) ☐ my or ☐ my dependents _____ (*Print name of dependents)* complete health record with the exception of the following information:
   ☐ Mental health records
   ☐ Communicable diseases (including HIV and AIDS)
   ☐ Alcohol/drug abuse treatment
   ☐ Other (please specify) _____
3. I understand the purpose for disclosing this personal health information to The Clerical Council for Family Affairs – Americas District. I understand that I can refuse to sign this consent form.
4. This medical/mental health information may be used by the person/organization I authorize to receive this information for review of any application filed by me or by my current or former spouse with the Clerical Council for Family Affairs-America District or other purposes as I may direct.
5. This authorization shall be in force and effect until the matter before the Clerical Council for Family Affairs-America District is concluded.
6. 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.
7. I understand the Clerical Council for Family Affairs-America District retains all information and/or files in full confidentiality and shall not disclose the documents to any administrative tribunal or court of law. The Council will not release documents under any condition pursuant to the guidelines of ecclesiastical confidentiality and religious privilege.
8. I understand that at no time shall I compel or subpoena the records of the Clerical Council for Family Affairs-America District relating to any matter I may have pending with them.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative Relationship to Patient