

¹HIPAA AUTHORIZATION FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize _____ to use and / or disclose certain protected health information (PHI) about me to _____.
Doctor or Facility's Name
Family Member or New Doctor's Name

This authorization permits _____ to use and/or disclose the following individually identifiable health information about me:
Doctor or Facility's Name

Specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.

The information will be used or disclosed for the following purpose:

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.
Expiration Date – 1 year from today's date is standard

I do not have to sign this authorization in order to receive treatment from _____.
Doctor or Facility's Name

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Doctor or Facility's Address

SIGNED BY

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____

RELATIONSHIP TO PATIENT _____

PRINT PATIENT'S NAME _____

PRINT NAME OF PATIENT OR LEGAL GUARDIAN, IF APPLICABLE _____

DATE _____

¹ From the American Academy of Family Physicians (www.aafp.org). Patient / guardian must be provided with a signed copy of this authorization form.