HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me/my child:

   His/her/its Name

   Address

   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying PRACTICE NAME in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for
   _____ .
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me/my child or to the purpose of the intended use or disclosure of information about me/my child:
   _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual or Guardian (The person about whom the information relates)	**Date of Individual/Guardian's Signature**	**Relationship to Patient**

A copy of this completed, signed and dated form must be given to the Individual or other signator.