Authorization Example:

NAME OF PRACTICE
ADDRESS OF PRACTICE

Patient's Name: ____
[Print or Type]

By my signature below, I give permission for the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under HIPAA (Health Insurance Portability and Accountability Act), as described below:

Specific description of the information to be used or disclosed, including the dates of service(s):

____
____
____
____

Persons or class of persons authorized to make use of this disclosure (who is giving this permission):

1. ____
2. ____
3. ____
4. ____

Person or class of persons to whom the use of disclosure may be made (who is getting this information):

1. ____
2. ____
3. ____
4. ____

The protected health information will be used and/or disclosed for the following purposes – (Please list each purpose of the use(s) or disclosure(s) in the space provided.)

____
____
____
____
____
____

____
____

[ ] At the request of the individual (check box if applicable
[ ] Other:

- I understand that, if the person or organization that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may not longer be protected by federal or state law. This information may no longer be "private" after it is released at your request.
- I understand that I may revoke or cancel this authorization at any time by notifying [NAME OF PRACTICE] in writing. If I choose to do so, I understand that my revocation will not affect any actions already taken before [NAME OF PRACTICE] received my cancellation/revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization will expire either on the following date: ______________________, or on the date that the following event occurs:
____
____

Print Name of Patient: ____

Signature of Patient: ____

Date: ____

Patient's Date of Birth: ____

Patient's Social Security Number: ____

For Personal Representative of the Patient (if applicable):

Print Name of Personal Representative: ____

Describe Personal Representative Relationship:
____

____
(parent, guardian, etc.)

Signature of Personal Representative: ____

Date: ____