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HIPAA DISCLOSURE AUTHORIZATION

Patient's Name:_____ Date of Birth:_____

Contact Phone #:_____

HIPAA regulations require we keep your health information confidential. You do have the right to grant access to this information to family members or other named persons. If you desire to provide your health information to family, significant other, or any other person: please complete this authorization.

Please list those individuals to whom you authorize the release of your health information (medical and psychological condition, diagnoses, test results, appointments, and other pertinent health reports):

Name:_____ Phone #:_____ Relationship:_____

Name:_____ Phone #:_____ Relationship:_____

Name:_____ Phone #:_____ Relationship:_____

This authorization has no expiration date. It shall be termed when withdrawn in writing.

Patient Signature:_____

Date Signed:_____