HIPPA AUTHORIZATION FORM

I authorize ___________________________to use and disclose my protected health information(PHI) listed below upon my request. This includes faxing this information to the designated entities or persons.

____Appointments ____Restrictions ____Medications ____Released from care

____Date of Visit ____Reason for visits ____Diagnosis

Entity or person(s) authorized to receive this information:
____School/Daycare/Preschool ____Camp ____Employer ____Social Worker
____Personal Representative's Employer ____Truant Officer ____Parole Officer
____Family/Friends

The PHI is being used or disclosed for the following purposes:
____Work/School Excuse ____To verify restrictions ____Verify return to work/school

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires:

____No longer in school ____Employment terminated ____Released from care
____Child reaches age of majority.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (office address or e-mail address). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may be longer be protected by federal or state law.

____ ____________________
Signature of Patient or Personal representative Date

____ ______________________________
Print Name of Patient or Personal Representative Personal representative's Authority