HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

Patient's Name:_____ Date of Birth:_____

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI")

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name:_____Relationship _____

Name:_____Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature:_____ Date:_____