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HIPPA Authorization FORM

I _____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED Health Information

_____, is authorized to disclose the following protected health information to

_____

_____

_____

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

All past, present and future periods of health care information may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is_____

4. VALIDITY OF AUTHORIZATION FORM

This authorization form is valid beginning on /__/__ and expires on___/___/___

5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this authorization form may be subject to re-disclosure by the person (s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form. If signed, I have the right to revoke this authorization in writing at any time. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

By :

A) Print Name

1 (Patient)_____ Date_____

2 (Legal Guardian)

B) Signature

1 (Patient)_____Date_____

2 (Legal Guardian_____ Date_____