Patient Consent & Authorization for Release of Protected Health Information

ease Print				
atient Name:			Da	ate of Birth:
ldress:				
	State: ZIP Co			ber:
nail Address:				
Patient Authorization				
,	, hereby authorize	the release, u	se or disclosure of my hea	alth information as follows
This authorization pertains t	the following type of medical info	rmation abou	it me:	
hereby authorize	Name of individual(s)			
	Name of individual(s)	and/or organiza	tion providing information	
o release the above-describe	d information toName	of individual(s) a	and/or organization receiving t	his information
I understand that, per my requ	est, this authorization will permit the	above-name	d parties to use or disclos	e the identified health
nformation for purposes beyo	nd treatment, payment, or healthcare			
and Accountability Act of 199				
I understand that I may revoke	e this authorization at any time by pro	oviding writter	n notification to:	
The revocation will be effectiv	e on the date it has been received and	processed by	the above-named recipie	nt. I understand that the
revocation does not apply to ac	tions taken in reliance upon this author	orization prior	to the effective date of rev	vocation. I also understand
	authorization in order to receive treat	Committee of the Commit		
Unless I request in writing oth	erwise, I understand that this authoriz	zation will exp	oire on	If I do not
necify an expiration date or ex	vent, this authorization will expire nin	nety (90) days	from the date on which I	te or event
	ion used or disclosed pursuant to this			closure by the named
ecipient, and may no longer t	e protected by HIPAA's privacy rules	after the auth	orized disclosure.	
Patient or Personal Rep	resentative			
nature:				Date://
me: Please Print				
ationship to Patient:				
For Office Use On	y			
				52.00 No.
Received by:			Da	ate://



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