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HIPAA Privacy Authorization Form

Authorization for the Use or Disclosure of Protected Health information
(Required by the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct)

I, _____ , authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name _____ DOB _____ Relationship _____

Name_____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

I understand that I have the right to revoke/or amend this authorization, in writing, at any time. Unless otherwise revoked, this authorization will be in force and effect one year from today's date at which time this authorization expires.

Patient Name _____ DOB ____/____/____

Signature _____ Today's date ____/____/____

A copy of this policy is available at your request