

HEALTHCARE

HIPAA Authorization

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below.

Patient Name:

Date of Birth:

AUTHORIZE DISCLOSURE TO

Name / Organization:

Address:

INFORMATION TO BE DISCLOSED

- Complete Medical Record
- Lab Results
- Imaging Reports
- Prescription History
- Mental Health Records
- Other (specify below)

PURPOSE

This authorization expires on the date specified below or one year from the date signed, whichever comes first. I may revoke this authorization at any time by submitting a written request.

Expiration Date:

Patient Signature:

Date:
