HIPAA 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 ____________________ of ___________________, ________________ _______________.

2 .DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

All past, present, and future periods of healthcare 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 __________________ and expires on _______________.

1411 North Flagler Drive, Suite 8200, WPB, FL 33401	P: (561) 612-3200 F: (561) 335-5424	intrepidfamilymedicine@gmail.com Intrepidfamilymedicine.com

5. ACKNOWLEDGEMENT

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, within 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.

Printed Name: ____

Signature: _____________________________________Date: ___________________

1411 North Flagler Drive, Suite 8200, WPB, FL 33401	P: (561) 612-3200 F: (561) 335-5424	intrepidfamilymedicine@gmail.com Intrepidfamilymedicine.com