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# HIPAA Disclosure Authorization Form

Full name: _____ DOB: _____

I hereby authorize:_____Family Practice Care, PLLC_____ to use or disclose

my protected health information to: _____

_____

This information is to include all medical records with exception of:

_____
*(Ex: mental health/certain test or lab results)*

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, with the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been take in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Signature of Individual or Representative Date

_____
Authority or Relationship to individual, if representative

EXPIRATION DATE: This authorization will expire on: _____

If no date is stated, the expiration date will be six (6) years from the date of this authorization.