HIPAA

HIPAA COMPLIANCE CLIENT CONSENT FORM

By signing this form, I authorize you to release confidential information about me, regarding my insurance, health status, or a summary or narrative of my protected health information, to the individual(s) listed below.

CLIENT NAME: ____________________________ DATE OF BIRTH: __________

Release my confidential information to the following individual(s):

Name: ________________________________ Phone#:__________________
Address:____
Relationship to you: ____
Information you may not want released to this individual:
____
____

Name: ________________________________ Phone#:__________________
Address:____
Relationship to you: ____
Information you may not want released to this individual:
____
____

Name: ________________________________ Phone#:__________________
Address:____
Relationship to you: ____
Information you may not want released to this individual:
____
____

Client Signature: ___________________________ Date:_______________

Your privacy matters!

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