HIPAA AUTHORIZATION FORM

Do we have permission to?

Leave a message on your answering machine at home? _____ YES _____ NO
Leave a message om your cell phone? _____ YES _____ NO
Leave a message at your place of employment? _____ YES _____ NO

Discuss your medical condition with members of your family or anyone else?
****_____ YES** _____ NO**

****If YES, please list below the name(s) of the people and their relationship to you. Please list your spouse and/or anyone who my call our office for you. If you do not list anymore, our doctors and office staff CANNOT discuss your medical information with anyone but you.**

****I give permission to the doctors and/or staff to release information (verbal or written) about me, my medical condition and or treatment to the following person(s):**

NAME OF PERSON (Please Print)	RELATIONSHIP
_____	_____
_____	_____
_____	_____

_____ do not discuss with any other than patient.

Signature below is acknowledgment that you have received the Notice of our Privacy Practices.

Print Name: _____

Patient Signature: _____ Date: _____

For Personal Representative of the Patient (if applicable)
Print Name of Personal Representative: _____

Representative's Relationship [i.e. parent/guardian/other, etc.): _____

Signature of Personal Representative: _____ Relationship: _____