Joseph P. Addabbo Family Health Center

HIPAA CONSENT TO RELEASE INFORMATION FORM

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

Patient's Name: _____ Account #: _____

Address: _____

_____

Telephone: _____

Acknowledgment of Receipt: I, the undersigned patient or other person legally authorized to act for the patient, have been provided with a copy of the Notice of Privacy Practices for Protected Health Information, and I have had the right to review the Notice prior to signing this Consent.

Consent for Use and Disclosure of Protected Health Information: I, the undersigned patient or other person legally authorized to act for the patient, understand and agree that all health information concerning the above-named patient ("Protected Health Information") shall remain the property of Joseph P. Addabbo Family Health Center. I consent to the use and disclosure of such Protected Health Information as described in Joseph P. Addabbo Family Health Center's Notice of Privacy Practices for Protected Health Information. Except for the reasons described in the Notice, I may revoke this Consent in writing at any time using the procedure in the Notice.

This is to certify that I, the undersigned patient or other person legally authorized to act for the patient, have read this Consent for Use and Disclosure of Protected Health Information and Acknowledgment of Receipt of Notice of Privacy Practices, understand its content, and accept its terms. I agree that this Consent supersedes any and all previous consents, authorizations, releases, and other written legal permissions signed by me regarding the use and disclosure of the Protect Health Information covered by this Consent, and I release Joseph P. Addabbo Family Health Center and its health care providers from all liabilities related to their compliance with this Consent.

_____ _____

Printed Name of Patient Patient Signature/Date

_____ _____

Printed Name of Patient's Parent/Guardian/ Other Legal Authorized Legal Representative

Signature of Patient's Parent/Guardian/ Other Legal Authorized Legal Representative

_____ Representative Telephone #: _____

Basis of Authority to Act on Behalf of Patient

Address of Patient Representative _____