HIPAA Authorization Form

I, [_____],

currently residing at

[_____], hereby authorize the use and disclosure of my protected health information as described below.

1. Patient Information:

- **Full Name:** [_____]
- **Date of Birth:** [_____]
- **Address:** [_____]
- **Phone Number:** [_____]
- **Email Address:** [_____]

2. Authorized Individual:

I authorize the release of my protected health information to the following individual:

- **Full Name:** [_____]
- **Relationship to Patient:** [_____]
- **Address:** [_____]
- **Phone Number:** [_____]
- **Email Address:** [_____]

3. Information to be Disclosed:

I authorize the disclosure of the following types of protected health information:

- Medical Records
- Treatment Plans
- Test Results
- Billing Information
- Other (Specify): _____

4. Purpose of Disclosure:

This authorization is granted for the following purpose(s):

- Coordination of Care
- Legal Proceedings
- Insurance Claims
- Other (Specify): _____

5. Duration of Authorization:

This authorization is effective immediately and will remain in effect until [Specify Date or Event], unless revoked by me in writing.

6. Revocation:

I reserve the right to revoke this authorization at any time by providing a written notice to the healthcare provider.

7. Confidentiality Notice:

I understand that once the information is disclosed, it may be subject to re-disclosure by the authorized individual and may no longer be protected by HIPAA.

8. Governing Law:

This HIPAA Authorization is governed by the laws of the

[State/Country_____ / _____] in which I reside.

9. Signatures:

I have executed this HIPAA Authorization on this

[Date_____]

day of [Month, Year_____ / _____].

[Your Signature]

_____

[Witness 1 Name]

_____

[Witness 1 Signature]

_____

[Witness 2 Name]

_____

[Witness 2 Signature]

_____