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AUTHORIZATION TO RELEASE INFORMATION

Due to the Health Insurance Portability and Accountability Act, (HIPAA), which is designed to protect patient’s privacy, we must now have your authorization to release any information.

I am authorizing the release of information regarding my health to any pharmacy, healthcare facility, physician, insurance, or precertification company so that approval, treatment, and care can be rendered or payment of services can be obtained. I am aware that this also allows my physician or a representative of my physician’s office the right to discuss my health for the purpose of their well being. I am aware that information may be shared by providers through faxes, phone conversations, electronic submissions, as well as general mail.

I am also allowing the release of information that requires doctor’s records or forms to be completed on my behalf. This would include forms for workers compensation, motor vehicle agencies, disability insurance, nursing home facilities, and schools.

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT’S SIGNATURE: _____