Elmwood Family Physicians

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient:_____

Date of Birth:_____SSN:_____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information.

- o All of my health information
- o My health information relating to the following treatment or condition:

_____

The purpose of this authorization is (check all that apply):

- o At my request
- o Other:_____

This authorization ends:

- o On (date)_____
- o When the following event occurs:_____

Sign:_____Date:_____