HIPAA - Cassandra Murray-Barja

HIPAA COMPLIANT AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary and is valid beginning with the date signed below and remains valid for one (1) year.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal Privacy Reguilations.

I acknowledge that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquire immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV); sexually transmitted disease, tuberculosis or genetics. If you do not wish this information to be released, please initial DO NOT RELEASE [ ] .

Patient Name:

Address:
Social Security No.: [ ]

Persons/organizations providing the information:

Persons/organizations receiving the information:

ROSENBAUM & ASSOCIATES, P.C. 1818 MARKET STREET, SUITE 3200 PHILADELPHIA, PA 19103-3611

Specific description of information: _____

What is the purpose of the use or disclosure? **Legal**

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on (DD/MM/YYYY)
   Initials [ ]
2. I understand that I may reveoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.
   Initials [ ]

Date:

Printed Name of patient's representative:

Relationship to the patient: _____

verified by approveme

X _____

Signature Certificate

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