HIPAA POLICY AND PRACTICES

This form is used to confirm the direction of an individual that we use or disclose protected health information for a purpose.

SECTION A: The individual (or the individual's Personal Representative) confirming the authorization.
Name: _____________________, yes you may leave a message on my answering machine or cell phone confirming appointments or other information.

SECTION B: Please list organizations we may disclose to: Primary Care Physician, Specialists Hospitals and other facilities.

__________________________________ ____________________________________

__________________________________ ____________________________________

SECTION C: Please list individuals we may disclose to: Family members, neighbors, close friends, etc.

_________________________________ _____________________________________

__________________________________ _____________________________________

SECTION D: Signatures for Acknowledgement and confirmation

I, ______________________, have had full opportunity to read and consider the contents of this authorization, and confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: ____________________________ Date: _____________________________