5900 N Main St #3 Dayton, OH 45415
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HIPAA Authorization Form

Patient Information:			
Last Name	First	Middle	DOB
Address	City	State	Zip
Email	Preferred Phone ❑ Ok to Leave Message	Alternative Phone ❑ Ok to Leave Message	

Purpose of Release:

I authorize my physician and/or their representative to disclose limited Protected Health Information, pertaining to me, to the following individual(s) who is authorized by me to receives such Protected Health Information for the purposes of informing them of my General Medical condition and diagnosis for treatment, payment, and other needs related to my healthcare.

Records Released To:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Termination and Responsibilities:

- This authorization will remain in effect until termination by me, my legally authorized personal representative or other individual(s) authorized to act on my behalf by court order or law.
- I am responsible for any changes or updates related to the individuals are list on this form as well as the contact information associated with those individuals.
- Right to revoke - I have the right to revoke this authorization by submitting a written request.

Disclosures made under this authorization may be redisclosure by the recipient and the information may not be protected by federal privacy laws or regulations.

Signature:

Signature of Patient	
Signature of Individual Authorized by Parent	Date
Relationship to Patient	