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Patient Authorization Form

I hereby authorize you to use or disclose any information pertaining to my account (including fees, payments, insurance, etc.) and treatment (completed or future).

Person requesting the information and authorized to make the requested use or disclosure (i.e. spouse, parent, child);

Name	Relationship to Patient

This authorization will remain in effect until revoked in writing.

I understand that:

* I may inspect or copy the protected health information to be used or disclosed.
* I may revoke this authorization in writing by contacting your office at the address below, Attention: Privacy Officer
* Information used or disclosed pursuant to the authorization may be subject to re-disclosure be the recipient and no longer be protected by HIPAA
* I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization

Patient Name:_____ Patient Acct#: _____

Signature: _____ Date: _____

Relationship to Patient (if signed by personal representative of Patient) _____