HIPPA Privacy Authorization

Consent to disclose clinical protected health and/or billing information to a designated representative.

By completing this form, we can communicate protected health information and billing information with a designated contact person. We are unable to discuss patient care with a spouse, family member, or anyone else unless this form is completed and signed by the patient.

Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

I, _____, hereby authorize my health provider, Matt

Harrison MD, to release protected health information regarding me

or my condition and treatment to:

_____	_____
Print name of representative	Relationship to patient
_____	_____
Print name of representative	Relationship to patient
_____	_____
Print name of representative	Relationship to patient

I understand that Dr. Harrison may still use and disclose protected health information as indicated in the Notice of Privacy Practices. This authorization is being granted at the request of the individual. Unless otherwise revoked, this authorization expires 12 months after the date of signing this form. I understand that I have the right to revoke this authorization at any time by sending written notification to the address listed at the bottom of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that I have a right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signed: _____ **Date:** _____

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