

**HIPPA AUTHORIZATION FORM**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

\_\_\_\_ Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Information is not to be released to anyone.

**Messages**

Please call: \_\_\_\_my home; \_\_\_\_ my work; \_\_\_\_\_ my cell

If unable to reach me:

\_\_\_\_\_ you may leave a detailed message

\_\_\_\_\_ please leave a message asking me to return your call

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best time to reach me is (day)\_\_\_\_\_\_\_\_\_\_ (time)\_\_\_\_\_\_\_\_\_\_\_

I understand and acknowledge that I have read, understand and agree to the policies and procedures of treatment as defined in the welcome packet.

\_\_\_\_\_ HIPPA

\_\_\_\_\_ No-Show/Cancellation Policy

\_\_\_\_\_ Phone Calls

\_\_\_\_\_ Payment Expectation

\_\_\_\_\_ Release of Information

Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_