The Center *for* Healthy Minds

HIPPA AUTHORIZATION FORM FOR FAMILY MEMBERS/OTHERS

I, _____(name of patient) give permission to all my health care and medical services providers to disclose and release my protected health information described below to:

NAME(S):	RELATIONSHIP:	PHONE NUMBER:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health information to be disclosed (Check all that apply):

___ My complete health records

___ Other (please specify)_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (indicate one):
___ All past, present, and future periods OR
____ Date or event: _____ Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)

_____ _____
Name of person giving this Authorization Date

_____ _____
Signature of person giving this Authorization Relationship

Patient's name_____ Date of Birth_____

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