HIPAA AUTHORIZATION FORM

I, _________________, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

_________________ is authorized to disclose the following protected health information to my Service Provider, HHF Authorized Service Personnel at Humanity & Health Foundation of Jonesboro, United States, Georgia 30238.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

All treatment records

All past, present, and future periods of health care information may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is ensure the right services or procedure is recommended for the client..

4. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _________________ and expires on _________________.

5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By: ____________________________________ Date: ____________________________________

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