**HIPAA PRIVACY AUTHORIZATION FORM**

I give this practice/clinic my consent to disclose my protected health information to carry out my treatment, to obtain payment from insurance companies & for health care operations like quality reviews.

I have been informed that I may review the practice/clinic’s Notice of Privacy Practices for a more complete discretion of uses & disclosures before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices & that I may obtain any received notices at the practice/clinic.

I understand that I have the right to request a restriction of how my personal health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request, in writing, except for information already used or disclosed.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by representative/guardian, state relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_