HIPAA AUTHORIZATION FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ DOB: _____

I. My Authorization

I authorize Primecare360 to access and use my current and past medical information as needed to continue my care. In addition, I authorize Primecare360 to share my medical records with other providers which are involved in my care.

To use or disclose the following health information: (check one) ☐ - All of my health information ☐ - My health information limited to: _____

II. Who to Contact Regarding Your Personal Health Information/Results/Condition

I hereby give my permission to Primecare360 to disclose and discuss information pertaining to my medical condition(s) to/with the following family members, relatives, or indicated persons.

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

III. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____ Date**:** _____