HIPAA AUTHORIZATION FORM

I,_____, give permission to Emmanuel Family Clinic to:

□ use the following protected health information, and/or

□ disclose the following protected health information to:

Names of entity or Person to receive information:

_____
_____
_____

Information to be disclosed (check all that apply):
□ Medical Records
□ Treatment Records
□ Diagnostic Records
□ Other: _____
_____
_____

This protected health information is being used or disclosed for the following purposes:
_____
_____
_____

This authorization expires on _) __/____.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment of your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to Emmanuel Family Clinic at 2ÿ31 Evans Street, Ste. A Newberry, SC 2910ÿ. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority