HIPPA AUTHORIZATION FORM

1585 Woodlake Drive, Suite 214 Chesterfield, MO 63017
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______________________________________ Patient's Full Name	______________________________________ Patient's Social Security Number/Medical Record Number
______________________________________ Address	______________________________________ Patient's Date of Birth
______________________________________ City, State, Zip Code	______________________________________ Patient's Telephone Number

I hereby authorize use or disclose of protected health information about me described below.

The following physician/medical facility/specific person or class of person is authorized to use or disclose information about me:

____

____

The following physician/medical facility/person (or class of persons) may receive disclosure of protected health information about me (WHO DO YOU WANT TO RECEIVE YOUR MEDICAL RECORDS):

____

____

The specific information that should be disclosed is (please give dates of service if possible)

____

____

Unless you sign here, **NO INFORMATION** ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *____
NO, DO NOT DISCLOSE THIS INFORMATION*_________________________________

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying _____________________________________in writing of my desire to revoke it. However I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- My purpose/use of the information is ____.
- This authorization expires on_______________,20__, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies may be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

________________________ **Signature of Patient***	________________________ **Date of Patient's Signature**	________________________ **Date of Birth or Social Security Number**
________________________ **Signature of Guardian* or Personal Representative of Patient's Estate**	________________________ **Date of Guardian's/Personal Representative's Signature**	________________________ **Description of Authority to Act for the Patient**

OFFICIAL USE ONLY

________________________ **Received**	________________________ **Processed By**	________________________ **Date**