HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I authorize all medical service sources and health care providers to use and/or disclose my protected health information ("PHI") to myself and/or my agent named in my **Durable Power of Attorney for Health Care.**
Patient Name: _____

2. Authorization for Release of PHI Covering the Period of Health Care (Check One):

☐ From (Date) _____ to (Date) _____ OR

☐ All past, present, and future periods

3. I authorize and give consent to The Doctor's Office to leave messages on my answering machine, voicemail, text message, and/or e-mail for the following: (Check All That Apply)

☐ Appointment Reminders ☐ Prescription Refills ☐ Medical Information ☐ Test Results

☐ Insurance/Payment Issues ☐ Email: _____ ☐ Text: _____ ☐ Mail

4. I authorize disclosure of my billing, health condition, treatment, and prognosis to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

5. This medical information may be used by the authorized persons for medical treatment, consultation, billing, claims payment, or other purposes as I may direct.

6. This authorization remains in effect until nine (9) months after my death or until (date/event):

_____.

7. I understand I may revoke this authorization, in writing, at any time, except where actions have already been taken based on this authorization.

8. I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

9. I acknowledge that Apogee Clinical Research, LLC, in collaboration with Laura Lee Taylor, MD, LLC, may access my medical records only to determine my eligibility for a clinical trial.

Printed Name: _____

Patient Signature: _____ **Date:** _____