PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTIVE HEALTH INFORMATION [HIPAA]

BY SIGNING, I AUTHORIZE PAPILLION FAMILY MEDICINE TO USE AND/OR DISCLOSE CERTAIN PROTECTIVE HEALTH INFORMATION (PHI) ABOUT ME TO:

☐ PARENTS OF MINOR CHILDREN:_____

☐ SPOUSE:_____

☐ SIGNIFICANT OTHER OR FRIEND:_____

☐ OTHER FAMILY MEMBERS:_____

_____

[Please indicate relationship to patient]

Limit: The line below limits Papillion Family Medicine to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be excluded; such as dates of service, certain health topics and/or discussions, origin of information, etc.)

_____

_____

This is an official HIPAA Authorization Form as requested by the US Government. You do not have to sign this form and will be treated whether or not you sign. You may change this form at any time with a new written form. You may write that you do not want to share particular parts of your medical record. If you decide not to sign this form, a representative of Papillion Family Medicine will sign below that you were given an option to sign.

SIGNED BY: _____ _____ _____

SIGNATURE OF PATIENT [OR LEGAL GUARDIAN] DATE RELATIONSHIP TO PATIENT

_____

PRINT PATIENT NAME

_____ _____

EMPLOYEE SIGNATURE FOR PATIENT DECLINE DATE