HIPAA Authorization Form

SENDER INFORMATION

Name: _____ Address: _____

City, State, ZIP Code: _____ Email address: _____

Phone number: _____ Date: _____ dd / mm / yyyy

RECIPIENT CONTACT INFORMATION

Recipient's name: _____ Recipient's address: _____

City, State, ZIP Code: _____

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ dd / mm / yyyy

Address: _____ City, State, ZIP Code: _____

Phone Number: _____ Email Address: _____

RECIPIENT INFORMATION

Full Name/Entity Name: _____ Address: _____

City, State, ZIP Code: _____ Phone Number: _____

Email Address: _____

DISCLOSURE DETAILS

Purpose of Disclosure

Description of Information to Be Disclosed

Persons Authorized to Make Disclosure

Persons Authorized to Receive Disclosure

Duration of Authorization

ACKNOWLEDGMENT AND PATIENT SIGNATURE

Patient's Signature

Date: _____ dd / mm / yyyy

HEALTHCARE PROVIDER SIGNATURE

Healthcare provider's Signature

Date: _____ dd / mm / yyyy

WITNESS INFORMATION

Witnessed by: _____ Date: _____ dd / mm / yyyy

Witness's Signature

CONSENT FOR ELECTRONIC SIGNATURE

Patient's Signature

Date: _____ dd / mm / yyyy