**HIPAA Authorization Form**

Patient Name Date of Birth

Street Address

City, State, Zip Code

Phone Number

Email Address

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| **Release of Information to Caregivers, Family, and Friends.** Our practice may release your Protected Health Information, with your written consent, to a friend or family member that is involved in your care, or to someone who assists in taking care of you. If you have a home health aide, one of your adult children, or someone else accompany you for your visit with one of our providers for management of a medical problems; these individuals may have access to your medical and billing information. For designees that you may ask to act on your behalf, we require you to provide us a signed authorization that details the following information of any and all designees: |

Name Relationship

Phone Number

Name Relationship

Phone Number

Name Relationship

Phone Number

I understand that:

* If St. Louis Society for the Blind and Visually Impaired is requesting this authorization, I am entitled to receive a copy of this authorization.
* I may revoke this authorization at any time by providing written notice to the Office Manager of St. Louis Society for the Blind and Visually Impaired.
* This authorization is voluntary and I may refuse to sign it. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization form.
* If this information is disclosed as provided in this authorization and the person receiving my information is not subject to the federal privacy protection regulations, my information may be subject to further disclosure by that person and the information will no longer be protected under the federal privacy protection regulations issued by the U.S. Department of Health and Human Services.

Signature of Patient or POA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or POA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete the following if signed by a personal representative:**

Relationship to patient or nature of authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information (address, phone number, and email address):