HIPAA Authorization & Consent

Use this form to identify people or organizations Adams Internal Medicine may communicate with regarding your care, billing, appointments, or records, as permitted by law and office policy.

PATIENT

Patient Name

Date of Birth

AUTHORIZED PERSON OR ORGANIZATION

Name

Relationship / Organization

Phone

Email / Fax

INFORMATION AUTHORIZED

- [ ] Appointment information
- [ ] Billing or insurance information
- [ ] Medical records
- [ ] Lab or imaging results
- [ ] Medication information
- [ ] Other limited information described below

Limits or special instructions

PURPOSE AND EXPIRATION

Purpose of disclosure

Expiration date or event

Revocation instructions discussed / received

AUTHORIZATION

I understand that I may revoke this authorization in writing except to the extent information has already been released in reliance on it. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except as permitted by law.

Patient / Authorized Representative Signature

Date

Printed Name and Relationship if not patient