CLERMONT URGENT CARE

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)
This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization
I authorize the following disclosing party: **CLERMONT URGENT CARE** to disclose the following protected health information Release / Send to:

Name (Title/Facility/Organization/ Person): _____

Address: _____

_____

Phone: _____ **Fax:** _____

Information to be disclosed / requested:

☐ Visit Summary	☐ EKG
☐ Laboratory Test (Please Specify)	☐ Medication List
☐ Other (Please Specify)	☐ Diagnostic Imaging

This protected health information is being used or disclosed for the following purposes: **Check One**
☐ **Continuity of Care -** (Provider's information provided above)

☐ **Personal -** If Record(s) is for patients: There is a **Fee of $10.00.** Please send **Money Order**

(No Checks accepted) made out to: **Clermont Urgent Care**

If patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ Years of age: _____

☐ - Patient is unable to sign / reason: _____

Signature of Authorized Representative: _____

Print Name of Authorized Representative: _____ Date: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other _____

II. My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by HIPPA Privacy Standards. I Understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part Pin a research) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is a valid original.

Signature of Patient: _____ **Date:** _____