Forte Family Practice HIPAA Release Form

Patient Name:_____Date of Birth_____/_____/_____

Social Security #:_____Phone: (_____)_____-_____

I authorize the following name(s) of person(s) to have access to my protected health information (PHI). For example, spouse, child, other family members, another physician office, etc.

Authorized parties:

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

I do not wish to allow any other party to access my records_____
Initial

I GIVE MY PERMISSION TO RELEASE ANY INFORMATION REGARDING:
(Initial applicable lines below)

_____ Substance Abuse _____Psychiatric/Mental Health _____HIV Info

Forte Family Practice Notice of Privacy Policy is detailed on how my information may be used and disclosed under state and federal law. I may obtain a hard copy of the privacy policy at any time. A copy of this authorization may be used in the place of the original. I understand that I may request restrictions to the Notice of Privacy Policy at any time. I am also aware the Forte Family Practice done not have to agree with restrictions I have requested.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient