

Boca Acupuncture
HIPAA Privacy Authorization Form

1. Authorization

I authorize _____ to use and disclose my health information
_____.

2. Effective Period

This authorization for release of information covers the period of healthcare from:
_____ to _____.

or

all past, present and future periods.

3. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

4. I understand that this information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date