

PRIVATE HEALTH INFORMATION AUTHORIZATION FORM

I authorize Dr. Minnoch to disclose the following private information to the entity identified and for the purpose listed below.

Description of the specific information to be used or disclosed:

Recipient of the information:

Name:
Address:
City/State/Zip:
Telephone:

Person requesting the information and authorized to make the requested use or disclosure:

Name: _____ Relationship _____

This information is being requested for the transferring of records.

This authorization remains in effect from the date signed below until the transfer of records.

I understand that:

I may inspect and/or copy the private health information to be used or disclosed

I may revoke this authorization in writing by contacting your office at the address above

Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA

I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization

Patient Name:

Signature: _____

Relationship to Patient: _____ **Date:** _____