

HIPAA AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information

Drs. Phipps, Levin, Hebeka, & Associates, Ltd.
970 W. Wooster St., Suite 125, Bowling Green, OH 43402

By signing, I authorize Drs. Phipps, Levin, Hebeka, & Associates, Ltd. to use and/or disclose certain protected health information (PHI) about me to the following persons and/or entities: (usually family members, etc.)

This authorization permits Drs. Phipps, Levin, Hebeka, & Associates, Ltd. to use and/or disclose health information about me, such as date(s) of services, type of services, diagnosis, prognosis, treatment(s), radiographs, photographs, electronic documents, typewritten documents, handwritten documents, and the origin of information, etc.) Additionally, I give permission for Drs. Phipps, Levin, Hebeka, & Associates, Ltd. to disclose my PHI in order to receive payment or other remuneration from a third party payers and/or administrators.

I acknowledge that I do not have to sign this authorization in order to receive treatment from Drs. Phipps, Levin, Hebeka, & Associates, Ltd. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at the address listed above.

Signature of Patient or Legal Guardian Relationship to Patient Date

Print Patient's Name Print Name of Legal Guardian, if applicable