



AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

This form is to advise you that Primary Care at Memorial Hospital must require authorization from any individuals who wish to grant family members' access to his/her medical information. This procedure is required as in accordance with the Health Information Portability and Accountability Act ("HIPAA") which was enacted to protect the privacy of individual's health information.

If you are 18 years or older and would like additional members of your family to have access to your protected health information, please print their name, check the appropriate box and sign your name where indicated.

I, hereby, grant permission for _____, to have
Print name of person allowed access to your information

access to my medical information. This person's relationship to me is: _____.

Verbal Chart Both

Print patient name: _____ Date of Birth: _____

Signature: _____ Date: _____

The HIPAA Privacy and Security Regulation govern the use and disclosure of Protected Health Information. To remain in compliance with federal law, Primary Care at Memorial Hospital is required by HIPAA to obtain authorization for others to access your account. This authorization will be in effect for one year from the date of your signature. You may revoke the authorization in writing, and this revocation will be effective for the future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.