HIPAA AUTHORIZATION

In compliance with Prevea Health Privacy Practices this form will allow you to designate an individual(s) to whom Prevea Health may disclose your protected health information. This may include individually identifiable information related to past, present or future appointment, medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires your separate written consent. If you do not want to designate an individual(s) to receive your protected health information, indicate "none" below.

Patient Name _____Date of Birth _____

Address _____City_____State:_____Zip_____

Telephone Number: (_____)_____

I do hereby authorize Prevea Health to disclose protected health information to the following:

1. _____ _____ **(____)**_____
Name Relationship to patient Telephone number

2. _____ _____ **(_____)**_____
Name Relationship to patient Telephone number

3. _____ _____ **(_____)**_____
Name Relationship to patient Telephone number

By signing below I acknowledge that I have had full opportunity to read and consider the content of this authorization and understand that my protected health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude Prevea Health from disclosing my protected health information as outlined by Prevea Health Privacy Practices.

I understand that I have the option to revoke this authorization at anytime at which time I can execute a new authorization. I also understand that unless revoked in writing by completing a new authorization form, this authorization will remain in effect until I choose to revoke it.

_____ _____
Patient Signature Date

_____ _____
Personal Representative (Relationship to Patient) Date

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