

# HIPAA AUTHORIZATION FORM

(permission from patient/patient's legal guardian to share personal medical information)

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Chappel Family Healthcare  
name of patient

and/or any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to pt. \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to pt. \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to pt. \_\_\_\_\_

I authorize Chappel Family Healthcare or the medical facility to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Chappel Family Healthcare in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

OR, if applicable-

\_\_\_\_\_  
Signature of Legal Guardian or Personal Rep  
Of Patient's Estate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Authority to Act for the Patient

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date