HIPAA Notice of Information Practices

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I, _____ authorize Be Healthy to discuss and disclose my health information with my doctor, psychologist, psychiatrist, insurance carrier and/or a governmental agency when needed.

I understand that signing this authorization is voluntary. And I have the right to revoke this authorization by writing at any time during care. This would not affect the use of those records for the care given prior to the written request.

I understand that my written consent need only be obtained one time for all subsequent care given in this office.

Patient Signature: _____

Parent or Legal Guardian: _____

Date: _____

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