THE VAZ CLINIC, P.A.

GARTH O. VAZ, M.D. ~ FAMILY PRACTICE

HIPAA Authorization Form

The Vaz Clinic has taken measures to protect all of our patients' private medical information. We will not release any information to anyone unless you have provided the requested information below. This includes people other than what is covered in our Notice of Privacy Practices. HIPAA (Health Insurance Privacy & Accountability Act) **does allow** us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment; your insurance company when trying to get your claims paid; your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, **am authorizing** the person/people listed below to obtain
(Print Patient Name)
medical information about myself. I understand that The Vaz Clinic is not responsible for the information provided as long as it is given to a person that I have listed below.

Name:_____ Relationship to Patient:_____Phone #:_____

Address: City: State: Zip:

Patient's Signature:_____ Date:_____

Patient Representative Signature:_____ Date:_____
(Parent or Legal Guardian)

****

I, _____, **do not** authorize The Vaz Clinic to release **any** of my
(Print Patient Name)
protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature:_____Date:_____

Patient Representative Signature:_____ Date:_____
(Parent or Legal Guardian)

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Consent to Use & Disclosure of Protected Health Information (HIPAA)

Your protected health information will be used The Vaz Clinic or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records.

You may request a restriction on the use or disclosure of your protected health information. The Vaz Clinic **may or may not** agree to restrict the use or disclosure of your protected health information. If The Vaz Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

The Vaz Clinic reserves the right to modify the Privacy Practices outlined in the notice.

I have reviewed this consent form & give my permission to The Vaz Clinic, P.A. to use & disclose my health information in accordance of the Federal Privacy Standards.

_____

Patient Name (Printed)

_____

Signature of Patient / Parent / Guardian

_____

Date