PATIENT AUTHORIZATION
Pursuant to HIPAA Regulations (45 C.F.R. § 164.508)

To Permit Use and Disclosure of Protected Health Information

By Any and All Health Care Providers
(Name of Covered Entity)

Re:	_____________________	**XXX-XX-_________**	__/__/____
	Patient Name	***Social Security Number***	***Date of Birth***

I am the patient named above. I reside at ____.

By signing this form, I authorize any of my health care providers to use or disclose to __________________ **or** ____ ____________________ any and all protected health information necessary for the purposes of managing my healthcare.

Their contact information is as follows:

I understand that information disclosed by a Health Care Provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of 45 CFR § 164.

The term “Health Care Providers” shall mean any individuals or entities who have provided or may be providing me with any type of health care or who have access to any of my protected health care information, including, but not limited to, my physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, insurance company, the Medical Information Bureau, Inc. or other health care clearinghouse.

I understand that I may refuse to sign this Authorization. I also understand that my attending physician or any other medical provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

This authorization remains valid until my death.

This ___ day of _____________, 20__.

____
PATIENT’S NAME

STATE OF NORTH CAROLINA
COUNTY OF ________________

I, __________________________, the undersigned Notary Public for ___________ County, North Carolina, certify that the following person personally appeared before me this day, and I have personal knowledge of the identity of the principal; he acknowledging to me that he voluntarily signed the foregoing document for the purpose stated therein and in the capacity indicated: ________________________.

This the ___ day of ______________, 20__.

____
Notary Public
My Commission Expires ______________