IMPC

INTERNAL MEDICINE & PEDIATRICS OF CULLMAN, P.C.

HIPAA AUTHORIZATION FORM

I authorize Internal Medicine & Pediatrics of Cullman, P.C. to use and disclose my protected health information (PHI) listed below upon my request. This includes faxing this information to the following designated entities or persons:

*Appointments *Restrictions *Medications *Release from care *Date of visit
*Diagnosis *Reason for visits

Entity or person(s) authorized to receive this information are as follows:

***School/Daycare/Preschool** *Camp *Employer *Social Worker

*Personal Representative's Employer *Truant Officer *Parole Officer *Family/Friends

This PHI is being used or disclosed for the following purposes:

***Work/School Excuse** *To verify restrictions *Verify return to work/school

This authorization shall be in force and effect until patient and or authorized representative signs a revocation of authorization in our office.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 1890 Alabama Hwy 157 Suite 430, Cullman, AL 35058. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient & Date of Birth Personal Representative's Authority

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