Center for Physical Medicine & Rehabilitation

HIPPA PRIVACY AUTHORIZATION FORM

Authorization for use or disclosure of protected health information
Required by the health insurance portability and Accountability Act

Patient Name: ______________________________ DOB: ______________

I, ______________________________, authorize the release of information including the diagnosis, records, examination, treatment, and billing to the following:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

Patient Signature: ______________________________ Date: ______________