UPSTATE
COMMUNITY MEDICAL

BREAST CARE CENTER

Community Campus

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HIPAA Authorization Form

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A:

I _____hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if there are any party/parties authorized to receive the information that are not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

Please provide a list of individuals (family/friends) in which you give your permission to receive medical information on your behalf.

Name	Relationship to Patient	Phone Number	All information
_____	_____	_____	Y/N*
_____	_____	_____	Y/N*
_____	_____	_____	Y/N*

*If you answered no to any of the above, please specify what information may be released in the area below.

_____
_____
_____

Section B: **The patient or the patient's representative must read and initial the following statement:** I understand that I may revoke this authorization at any time by notifying the practice in writing; however, if I do it will not have any effect on any actions that were taken prior to receiving the revocation. **Patient's initials:** _____

X_____ **Date:** _____
Signature of patient or patient representative

_____ _____
If patient representative, please print name **relationship to patient**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION