CANYON VIEW MEDICAL

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act --- 45 CFR Parts 160 and 164)

Name: _____ Date of Birth: ____/____/____

A. I give authorization for release of my protected health information (PHI) to **Canyon View Medical Group** regarding my billing, condition, treatment and prognosis to the following individual (s):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

☐ Information is not to be released to anyone

B. This authorization is in effect until 2099, or until the following date: ____/____/____

C. I understand that I have the right to revoke this authorization verbally and/or in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

D. 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.

Signed: _____ Date: ____/____/____

If not signed by the patient, please indicate relationship or authority to sign: _____

I understand that my health care will not be affected if I do not sign this form.