EBW Clinic

Elizabeth B. White, MD

HIPPA RELEASE OF INFORMATION AUTHORIZATION FORM

I hereby authorize Dr. Elizabeth White`s Office and its affiliates, its employees and agents to release my personal health information maintained by Dr. Elizabeth White`s Office to other healthcare providers, in the event that a referral is required, for the purpose of diagnosis, treatment, claims payment, and health care services provided or to be provided to me and the information contains and identifies my name, address, social security number, member ID number and medical records.

This authorization is valid from the date of my/my representative's signature below and shall expire upon my death or written notice to revoke.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment or payment for coverage of services.

I request the following restrictions to the use and disclosure of my health information:

____

Do we have permission to speak to any other person and/or persons regarding your healthcare and medical condition? If so, who?

____

Name of Authorized Person Phone

Name of Patient: ____

Signature of Patient: ____

Date: ____

If applicable, Legal Representative sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative:

____

Signature of Legal Representative:

____

Date: ____________________

Name of Witness: ____

Signature of Witness: ____