Please include your ***email address*** for access to your *personal*

Online Medical Record/Portal with

https://myhealthrecord.com

Name (first & last): ______________________________

Email Address: ___________________________________

You will receive an email invite from us to enroll!

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPPA)

As required by the Health Insurance Portability and Accountability Act of 1996, Storm Clinic Prof. LLC may not use or disclose our health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, ______________________, (print patient name or name of minor child) hereby authorize and request the use and disclosure of all the health information that pertains to me. I authorize and request Storm Clinic PLLC to make these disclosures of my health information. I authorize and request the following persons to receive these disclosures of my health information and elect not to provide statement of purpose for the use of the disclosure to the following persons (please print):

____	___________	______________________________
Signature of Patient or Parent of Minor Child	Date	Relationship

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected.

I understand that this authorization will automatically expire on December 31st, 2018, but that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Storm Clinic, Prof. LLC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.