



AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 of 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):

Name

Relationship

Name

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.

Signature of Patient or
Parent of Minor Child

Date

Social Security Number

ONLY COMPLETE THIS SECTION IF YOU WISH TO REVOKE THIS AUTHORIZATION:

I revoke this authorization effective _____ (date).

Signature

date