APEX MEDICAL CENTER

HIPAA AUTHORIZATION FORM

(Permission from patient/patient's legal guardian to share personal medical information)

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

Phone Number: _____ State: _____ Zip: _____

I, _____ hereby authorize Apex Medical Center to release any and all medical information and test results that pertain to me to the following individuals:

1.) Name: _____ Soc Sec #: _____
(verify last 4 digits)

Relationship to Patient: _____

2.) Name: _____ Soc Sec #: _____
(verify last 4 digits)

Relationship to Patient: _____

3.) Name: _____ Soc Sec #: _____
(verify last 4 digits)

Relationship to Patient: _____

I authorize Apex Medical Center or the medical staff to contact the above named individuals listed to convey any pertinent information to me, in the even that I am unable to be reached by Apex Medical Center.

I understand that I may revoke or cancel this authorization by notifying Apex Medical Center in writing of my intent to change names) of individuals to whom information is to be released or revoke this authorization.

Patient Name (please print): _____ Date: _____

Signature of Patient/Guardian: _____

Witness Signature: _____ Title: _____