Therapy Matters, Inc. HIPAA Form

Patient's Full Name | **Patient's Social Security Number/Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/Her/its Name

   Address

   City, State Zip Code

Parent/Guardian Name:

_____

Parent/Guardian Signature:

_____

Date:

_____