

FPA HIPAA AUTHORIZATION FORM

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, _____, give permission to Family Practice Assocs. of Exton & Marshallton (FPA) to:

- use the following protected health information, and/or
- disclose the following protected health information to:

[Name(s) of entity to receive information]

Information to be disclosed (check all that apply):

- Medical Records
- Treatment Records
- Diagnostic Records
- Other: _____

This protected health information is being used or disclosed for the following purposes:

This authorization expires [specify (1) date or (2) event that relates to the purpose of this use or disclosure].

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to FPA at 770 W. Lincoln Highway, Exton, PA 19341-2547. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Signature of Participant or Personal Representative

Date

Printed Name of Participant or Personal Representative

Description of Personal Representative's Authority