FAMILY FOCUSED CARE
HEALTH FUSION OF TEXAS

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health InsurancePortability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ Date of Birth: _____

I authorize Family Focused Care and Health Fusion of Texas to use or disclose the following health information (check one)

☐ All my health information

☐ My health information relating to the following treatment or condition:

_____

☐ My health information covering the period from _____ (date) to _____ (date)

☐ Other: _____

The above party may disclose this health information to the following recipient(s):

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____

If the patient is a minor, please complete the following

Patients Name: _____

Parent Name or Guardian: _____

Parent or Guardian Signature: _____ Date: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization.

Patient Name: _____ Patient Signature: _____ Date: _____