



2019 HIPAA AUTHORIZATION FORM

I authorize the following individual to have full access to my health information:

Print Name/Phone #	Relationship	Date
Print Name/Phone #	Relationship	Date

I, _____ give my permission for you to leave any medical / lab information for me at the following phone numbers. I further consent to receiving medical reminders via text or email or will opt-out as noted below.

		Opt-Out
Home #		<input type="checkbox"/>
Mobile #		<input type="checkbox"/>
Work #		<input type="checkbox"/>
Email		<input type="checkbox"/>

Signature of Patient or Guardian	Date
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