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 #		☐
Mobile #		☐
Work #		☐
Email		☐

_____ _____

Signature of Patient or Guardian Date