UNIVERSITY OF THE PACIFIC

HIPAA Authorization Form for Use or Disclosure of Patient Information

Patient Name:	
Patient # (if applicable)	Date:

I hereby authorize the use and disclosure of the patient information described below. I understand that information disclosed through this authorization may be subject to re-disclosure and may no longer be protected by privacy rules.

Specific description of the patient information to be used or disclosed:

Purpose of the use or disclosure:

Person(s) authorized to make the disclosure:
Person(s) authorized to receive the information:

I understand I may refuse to sign this authorization and that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the University. If I revoke this authorization, my revocation will not affect any actions taken by the University before receiving my written revocation.

Expiration date or event:

_____ _____

Signature of Patient or Personal Representative Date

_____

Authority of Personal Representative