HIPAA AUTHORIZATION FORM

*The following persons or organizations are authorized to make the request for my protected health information:_____

*The following persons or organizations are authorized to receive my protected health information:_____

*This authorization for health information applies to the specific information set forth below (*provide a specific and meaningful description*):_____

*Unless a different date is specified, this authorization will expire 2 years from the date it is signed:_____

I certify that I have read and signed a copy of this authorization, a copy is available at my request.

_____ _____

Name of Patient (*please print*) Date

_____ _____

Signature of Patient (*or patient representative*) Date

_____

Relationship of Representative to Patient

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I HAVE READ AND/OR BEEN FURNISHED A COPY OF THE "Notice of Privacy Act" for Enterprise Valley Medical Clinic. The information on this form is accurate and complete to the best of my knowledge. I will not hold Enterprise Valley Medical Clinic or any member of the staff responsible for any errors of omission that I may have made in completing this form. Medical insurance is a contract between the insured and the insurance carrier. The patient is responsible for the total fees charged for services rendered at our office. We are happy to bill your insurance. I agree to pay all fees that are incurred during my exam or treatment of the above patient. I also understand that I am responsible for any balance not paid by my insurance carrier.

Co-payment is expected at the time of service.

_____

Signature of Patient or Person Responsible for Patient Date

_____

Office Staff Verification Initials Date