HEALTH, HEALING, HOPE®
DocCare®

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

I certify that I have received and read Doc Care's Notice of Privacy Practices and that all my questions regarding the health Insurance Portability and Accountability Act (HIPAA) have been answered as they pertain to my Protected Health Information. I authorize DocCare to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

Your consent is needed to release your medical information to another party. Please list the party(ies) you wish to have access to your medical information (ie) son, daughter, father, mother, etc.

NAME	RELATIONSHIP	PHONE NUMBER

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that DocCare has acted in reliance upon this authorization. My written revocation must be submitted in writing to the Administrator.

Signed By:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Today's Date

_____ _____
Print Name of Patient or Legal Guardian Expiration Date