MET PLUS HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize MET PLUS

to use or disclose the following health information.

- My health information relating to today's treatment & visit.

II. My Rights

I understand that I have the right to revoke this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my permission cannot be taken back.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____