logo

 PHARMACY NAME

ADDRESS

PHONE & FAX NUMBERS

**HIPPA AUTHORIZATION FORM**

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, **DOB**:\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby authorize the use or disclosure of my protected health information as described below:

**AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** is authorized to disclose all protected health information including but not limited to Clinical Notes related to my care to my Clinical Care providers at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In turn my Clinical Care providers at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ are authorized to disclose all of my protected health information as is related to my care provided by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This Authorization is valid beginning on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I agree that this HIPPA AUTHORIZATION will remain valid for each repeated Long-Acting Injectable Antipsychotic (LAIA) injection administered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) of facility receiving it and then would no longer by protected by federal privacy regulations.**

**I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance**

**on this authorization cannot be reversed, and my revocation will not affect those actions.**

**By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**