# HIPAA COMPLIANT PATIENT AUTHORIZATION FORM

**To: Dr. Capelle**
**3496 University Avenue**
**Morgantown, WV 26505**

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described.

Description of the specific information to be used or disclosed: (please check mark the items that you are requesting).

- ☐ Office Notes
- ☐ History & Physical
- ☐ Hospital Summary
- ☐ Operation Reports
- ☐ Pap Smear
- ☐ Lab
- ☐ Pathology
- ☐ Ultrasounds
- ☐ X-ray
- ☐ Mammograms
- ☐ Other

Person or entity requesting the information and authorized to make the requested use or disclosure:
_____
_____
_____

Recipient of the information: _____

The information is being requested for the following purpose(s):
_____
_____
_____
_____

The authorization shall remain in effect from the date signed below until
_____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).
- ☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name:_____ Signature:_____
Social Security Number: _____ D.O.B. _____
Relationship to Patient
(if signed by personal representative of Patient):_____ Date:_____

Print Form