

HIPAA Medical Authorization Form

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND REPORTS

FULL NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO: _____

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Date: _____

Patient or Patient Representative _____
(Signature)

Name of Patient's Representative _____
(Print Name)

Relationship _____

Description of Representative's Authority to Act for the Patient

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

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Joacim Rocklöv



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