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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.

Hipaa Forms For Medical Offices

DJ Losen



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Unveiling the Magic of Words: A Review of "**Hipaa Forms For Medical Offices**"

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