Limited Use HIPAA Authorization

Patient Name

Date of Birth

Healthcare Provider/Entity Authorized to Disclose Information

Recipient (Who will receive information)

Description of Information to be Disclosed (be specific)

Purpose of Disclosure

Expiration Date or Event

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, describe authority:

Important Information

- You may revoke this authorization at any time in writing.
- This authorization is not required for treatment, payment, or enrollment.
- Information disclosed may no longer be protected by HIPAA once released.