HIPAA WAIVER FORM

Patient Information	
First Name	**Last Name**
Date of Birth	**Age**

Health Records Disclosure
Type of Health Records to be Disclosed
Period of Allowed Health Records Disclosure
Authorization Expiration Date

By signing this form, I understand and acknowledge that I may revoke this waiver at any time in writing. However, in cases where disclosures have already been made prior to revocation, I understand that such revocations may not be taken back.

Under the HIPAA Privacy Standards, I understand that parties who are not a party to this agreement may possibly redisclose the information.

I understand that this disclosure is not mandatory, and I may choose not to sign this waiver. I understand this waiver may not be conditioned upon a treatment.

I understand that upon submission of this waiver, I will receive a copy. The copy that I receive shall be deemed an original.

Signature: **Signature Date:**