

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: