HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: _____

Date of Birth: ___ / ___ / _____

Address: _____

Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use or disclosure of the following protected health information:

[ ] Complete Medical Record

[ ] Specific Records (please specify): _____

[ ] Other (please specify): _____

Recipient Information

Recipient Name: Ready Set ABA, LLC

Phone Number: (704) 222-7654

Fax Number: (844) 444-0621

Purpose of Disclosure

Legal/Insurance: _____

Other (please specify): _____

Expiration of Authorization

This authorization will expire upon the occurrence of:

_____

Acknowledgment and Signature

I understand that:

- I may revoke this authorization at any time by providing written notice to Ready Set ABA, LLC.

- Revocation will not affect information that has already been disclosed prior to receipt of the revocation.

- This authorization is voluntary, and I may refuse to sign it.

- Once information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

- I have the right to receive a copy of this authorization.

Signature of Patient or Legal Representative: _____

Printed Name of Legal Representative (if applicable): _____

Relationship to Patient: _____

Date: ____ / ____ / _____