HORIZONS DIAGNOSTICS
Caring for Our Community

HIPAA AUTHORIZATION FORM

Horizons Diagnostics has taken measures to protect our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These are people other than what is covered in our Notice of Privacy Practices. HIPAA (Health Insurance Privacy & Accountability Act) does allow Horizons Diagnostics to release information to outside entities on your behalf.

Patient Name (Last, First):	Patient DOB:	Primary Care Physician Name:

I authorize the person/people listed below to obtain medical information about myself.

I understand that Horizons Diagnostics is not responsible for the information provided if it is given to a person that I have listed below. Please Complete and check the options that apply.

Name (Last, First):	Phone Number:	Relationship to Patient:
☐ - All of my health information ☐ - My health information relating to the following treatment or condition:		

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☐ - All of my health information ☐ - My health information relating to the following treatment or condition:		

Consent to Use & Disclosure of Protected Health Information (HIPAA)

Your protected health information will be used by Horizons Diagnostics or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. Horizons Diagnostics reserves the right to modify the Privacy Practices outlined in the notice.

I have reviewed the consent form and give my permission to Horizons Diagnostics to Use and Disclose my health information in accordance with the Federal Privacy Standards

Patient/ Legal Guardian Signature Date

Signature of Witness Date