Quanita Crable, M.D.

Exceptional Care for Exceptional Women

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

****1. Authorization****

I _____ authorize (The office of Quanita Crable, MD) to use and disclose the protected health information described below to the individual(s) seeking the information.

_____Spouse_____

_____Other Member(s) of my Family_____

_____Other_____

****2. Effective Period****

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present and future periods.

****3. Extent of Authorization****

a. □ I authorize the release of my complete health record.

b. □ I DO NOT authorize the release of my complete health record.

****This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.****

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I_____have been allowed to review/and have been offered a copy of Dr. Crable OB/Gyn P.A. Privacy Practices.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date