Cory Brown, DPM

1630 23rd Ave., Suite 1001 Lewiston, ID 83501

HIPAA Privacy Authorization
Authorization for Use or Disclosure of protected health information required by the Health Insurance Portability and Accountability Act.

- I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information described below.
- This medical authorization may be used by the person(s) I authorize to receive this information for medical treatment, billing, claims, payment, or other purposes noted unless otherwise stated.
- I understand that I have the right to revoke or change this authorization at any time.
- I understand that information used or disclosed to listed person(s) may no longer be protected byfederal law.

1. _____

Name of Authorized *Relationship*

2. _____

Name of Authorized *Relationship*

3. _____

Name of Authorized *Relationship*

***** _____ _____

Patient Signature *Date*

******Authorization is active for 1 year of date of signature*