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HIPAA
PATIENT AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Authorization you may also request a copy of our Notice of Privacy Practices from our Office Manager.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Authorization in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Authorization. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Authorization in writing at any time. My revocation must be in writing and submitted to the Office Manager. If I do revoke this authorization, however, my revocation will not affect any prior actions taken by Phase II Sexual Medicine & Menopause Center in reliance on my authorization.
- If I have any questions about this authorization, I may contact the Office Manager at (801)272-6100 who will provide me with more information about this authorization or about Phase II Sexual Medicine & Menopause Center privacy practices.

Signed By: _____
Printed Name – Patient or Representative

_____ _____
Signature Date

_____
Relationship to Patient (if other than Patient)