HIPAA AUTHORIZATION FORM
(Authorization to exchange protected health information with someone else)

I _____authorize the staff at Brightland Health to release or receive confidential professional information to and/or from:

_____
(Name of other person: relative, physician, therapist, agency ect.)

_____
(address, city, state, zip code)

_____
(phone)

_____
(email)

This authorization will be valid for 12 months from the date of signing and is limited only to that information that I have hereby requested to be released to the person/facilities named herein.

_____ _____
Signature of Patient (or Authorized Representative) Date

_____
Witness