George M. Joseph, M.D. & Associates
2370 3rd St. South Suite 1
Jacksonville Beach, FL 32250

Phone: (904) 280-3552
Fax: (904) 280-3571
www.GEORGEJOSEPHMD.com

HIPAA AUTHORIZATION FORM

I, ____________________, give permission to George M. Joseph, M.D. & Associates to:

___ obtain the following protected health information, and/or

___ use the following protected health information, and/or

___ disclose the following protected health information

Information to be disclosed (check all that apply):

___ Behavioral Health Records
___ Medical Records
___ Treatment Records
___ Diagnostic Records
___ Other: ______________

To/From:
Name:____
Address:____
Phone:____
Fax:____

This authorization expires 30 days from the date specified below. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. Finally, you may revoke this authorization in writing at any time by sending written notification to George M. Joseph M.D., PA 2370 3rd St. South Suite #1 Jacksonville Beach, FL 32250. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____
Signature of Participant or Personal Representative

_________________ ______________________
Today's Date Date of Birth

____
Printed Name of Participant or Personal Representative

____
Signature of Witness