SCHLAMP MEDICAL CLINIC

921 1st Avenue • Sulphur, Louisiana 70663
337.527.6385 Phone • 337.527.3527 Fax
www.Schlampmd.com

HIPPA Authorization Form

Date: _____
Patient name: _____ DOB: _____
Parent if minor: _____ DOB: _____

Schlamp Family Medical Clinic has taken measures to protect our patients' entire private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) **does allow** us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, and your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, **am authorizing** the person(s) listed below to obtain medical information about myself. I understand that Schlamp Family Medical Clinic is not responsible for the information provided as long as it is given to a person that I have listed below. ***Date of birth must be provided to verify that we are speaking to the correct person.***

Name:_____ Date of birth: _____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth: _____

Patient's Signature:_____ Date:_____
(Parent if minor)

I am requesting that all communications regarding my protected health information including billing/accounting, lab results and scheduled appointments be handled in the following confidential manner:

_____ on my answering machine at home
_____ on my cell phone
_____ with the person(s) listed above.

I have received a copy of this HIPPA Authorization Form.

Patient's Signature:_____ Date:_____
(Parent if minor)

If unsigned by patient, parent or guardian the reason was:

_____ Patient was undergoing emergency treatment
_____ Patient declined to sign acknowledgment