HIPAA AUTHORIZATION FORM

I understand that Congress passed a law entitled the Health Insurance Portability and Accountability Act (HIPAA) that limits disclosure of my protected medical information. I understand that my protected medical information may be given to the following authorized persons in my absence.

I, _____ authorize Pumps It, Inc. to disclose protected health information pursuant and in compliance with this valid authorization under 45 CFR Sec. 164.508 to the following authorized persons:

Release of Information

□ Spouse Name _____

□ Child(ren) Name _____

□ Other Name _____

□ Information is not to be released to anyone.

I have the right to refuse this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signed: _____ Date: _____

Typing your name or initials will be used as your digital signature.