Dear Doctor, Medical Practice, Laboratory, Medical Service Center,

RE: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date:

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

First Name

Last Name

Address

City

State

Zip Code

Email

Phone Number

Gender

SSN (Last 4 digits only)

II. AUTHORIZATION. I authorize the following medical office/ Healthcare Provider ("Authorized Party") to use or disclose All of my medical-related information. Hereinafter known as the "Medical Records."

Practice/Lab Name

Doctor Name

Address

City

State

Zip Code

Email

Phone Number

Fax

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

Healthlynked Patient Medical Record Service

1265 Creekside Pkwy Suite 200 Naples, FL 34108

Phone Number: 1-800-928-7144

Website: www.HealthLynked.com

Email to: support@healthlynked.com

Fax to: +1 866-542-1082

Use the attached face sheet with bar code.

** See instructions on the face sheet

IV. PURPOSE. The reason for this authorization is:

General Purpose. At my request to help me better manage my medical information.

V. TERMINATION. This authorization will terminate:

Upon sending a written revocation to the Authorization Party.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date:

Print Name:

Print Form