HIPAA AUTHORIZATION FORM

I, ______________________________ give permission to **The Migraine Headache Relief Center of Pennsylvania** to:

- ○ **USE** the following protected health information, and/or
- ○ **DISCLOSE** the following protected health information to:
  - ○ PARENT
  - ○ GUARDIAN
  - ○ OTHER (specify): ____

INFORMATION TO BE DISCLOSED (check all that apply):

- ○ DENTAL RECORDS
- ○ DENTAL TREATMENT RECORDS
- ○ DIAGNOSTIC RECORDS
- ○ OTHER (specify): ____

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 revoke this authorization in writing at any time by sending written notification to:

The Migraine Headache Relief Center of Pennsylvania
300 Old Forge Lane - Suite 301
Kennett Square, PA 19348

Your notice will not apply to actions taken by the person or entity requesting your HIPAA Authorization prior to the date we receive your written request to revoke authorization.

______________________________ *Signature of Participant or Representative*

______________________________ *Printed Name of Participant or Representative*

______________________________ *Description of Participant or Representative's Authority*

______________________________ *Date*

REGARDING YOUR PRIVACY:

We encourage you to read our **NOTICE OF PRIVACY PRACTICES** which describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us. You can find this notice at: **http://headachereliefpa.com/forms/**