Synapse Association Inc.
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Phone (530)924-4038 Fax: (530) 924-4816
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Authorization to Release Protected Health Information

My Notice of Privacy Practices provides information about how I may use and disclose protected health information (PHI) about you. On occasion, you or Synapse Association Inc. and staff including Dr. Hah may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I,_____DOB:_____

Authorize Synapse Association Inc. and staff including Dr. Hah to release/obtain information from/to:

_____

_____

_____

The information I am authorizing Synapse Association Inc. and staff including Dr. Hah to release/obtain includes:

_____

_____

This information is required for the following purposes:

_____

Expiration date of this authorization: _____

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to Dr. Hah directly.

This authorization was signed by:

_____

Printed Name – Patient or Representative

_____ _____

Patient or Representative Signature Date

_____

Relationship to Patient (if other than patient):