THE BOSTER CENTER
FOR MULTIPLE SCLEROSIS
A Singlepoint Healthcare Company

Patient Name: _____ Patient DOB: _____

8000 RAVINES EDGE COURT, SUITE 200 | COLUMBUS, OH 43235
PH: (614) 304-3444 | FAX: (614) 304-3433 | INFO.BOSTER@SINGLEPOINTHC.COM

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

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.

Patient Information:

Name: _____

Date of Birth: _____

Social Security Number: _____

Release Records To: ○ Facility/Provider ○ Patient ○ Other: _____

Specify facility/provider/patient/organization name, address, and contact information:

Name: _____

Address: _____

Phone: _____ Fax: _____

Records Request Information:

Date(s) of the covering period(s) of health care: _____ to _____

Information authorized for disclosure:

- ○ Clinic Documentation
- ○ Infusion Documentation
- ○ Laboratory Data
- ○ Other: _____

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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: _____

Printed Name: _____

If patient is unable to sign, please use the signature area below:

Patient is unable to sign due to (check one):

- ○ Being a minor: patient is _____ years of age and considered a minor under state law
- ○ Being incapacitated: patient is incapacitated due to _____
- ○ Other: _____

Signature of Representative: _____ Date: _____

Printed Name: _____