HIPPA Authorization

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment, and payment activities.

Before signing please read our Notice of Privacy Polices to gain a clear understanding of how we may use and disclose your PHI.

I have read and understand your Notice of Privacy Policies and I consent for you to use my PHI for the purposes of healthcare operations and treatment and payment activities.

Signature/Date