**Health Insurance Portability and Accountability Act Privacy Regulation (HIPPA) Authorization To**

**Use or Disclose Protected Health Information**

1. I hereby authorize **Pyramid Nutrition Services, Inc** to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
2. Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. Information to be disclosed to: Pyramid Nutrition Services, Inc

33 Mulberry St 14 South Westfield St 77 Mill St., Ste 233

Springfield, MA 01105 Feeding Hills, MA 01030 Westfield, MA 01085

Phone: (413) 330-8167

Fax: (413) 480-0517

1. Disclose the following information:

[ X ] Complete Records [ ] Consult [ ] Outpatient Reports

[ ] Emergency Reports [ ] Face Sheet [ ] Discharge Summary

[ ] Laboratory [ ] History & Physical [ ] Pathology

[ ] Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. The above information is disclosed for the following purposes:

[ X ] Medical Care [ ] Legal [ ] Insurance [ ] Personal [ ] Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. I understand I may revoke this authorization at any time by requesting such of the above-referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. If the requestor or receiver is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, if I ask for it.
6. I get a copy of this form after I sign it, if I ask for it.
7. This authorization expires six months after end of treatment.

8. Signature of Patient or Legal Representative:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date**\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Relationship to minor patient or authority to act for patient:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed name of minor patient or patient’s representative

**In certain situations, an additional authorization to release sensitive, legally protected information may be required.**