PROFESSIONAL
SPEECH & HEARING
SPECIALISTS

HIPPA Authorization Form for Family Members/Friends/Caretakers

I,_____, authorize the following person(s) to have access to know and understand my condition, my treatment and treatment options.

_____	_____	_____
Name(Printed)	Relationship	Telephone Number
_____	_____	_____
Name(Printed)	Relationship	Telephone Number

This authorization shall be effective until (check one):

____All past, present, and future periods, OR
____Date or event:_____
Unless I revoke it.(Note: You may revoke this authorization in writing at any time by notifying our office.)

_____	_____
Signature of the Individual Giving this Authorization	Date

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