HIPAA AUTHORIZATION FORM

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

_____ is authorized to disclose the following protected health information to my Grant Assistant, Michelle Power at Pawsitively 4 Pink of Worcester, Massachusetts 01604.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

Other: Diagnosis, Treatment

Only health information from _____ to _____ may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is Validation of Diagnosis for Grant assistance.

4. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _____ and expires on

_____.

5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signed of behalf of _____ by _____, patient's

_____.

By: _____ Date: _____