Psychological Associates, P.A.
1120 North Palafox Street
Pensacola, Florida 32501-2608
Telephone (850) 434-5033
Fax (850) 433-0268

HIPAA AUTHORIZATION FOR COMMUNICATION OF PERSONAL INFORMATION

Print Name of Patient: _____ Date of Birth: _____

I hereby authorize Psychological Associates, P.A.:

To communicate the following information on my behalf:

Scheduling and verification (date/time) of my appointments, requests for medication refills, account information, billing, payment and insurance information

To the following parties:

Name: _____

Name: _____

This authorization is valid for an unlimited amount of time or until it is rescinded by the Patient.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age.

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Print Name of Authorized Representative: _____ Date: _____

Authority of representative signing: ☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _____

FOR OFFICE USE ONLY: Recorded in patient alert notes on _____ by _____.