Holvik Family Health Center

HIPAA Waiver

A. Statement of Intent It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my Individually Identifiable Health Information to certain of my family and friends, regardless of my state of health. I am signing this authorization so my health care providers can disclose my health care information to the person(s) listed below, and openly discuss that information with them.

B. Authorization I, _____, hereby authorize my physicians, nurses, hospitals, and other health care providers to fully disclose my Individually Identifiable Health Information to any or all of the following authorized person (s):

Personal Representative: (Example Spouse, Parent, etc.)

Name (s) of
Representative: _____

Address: _____

_____ _____
Signature Date