HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ Date of Birth: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

To Use my health information relating to the following treatment or condition:

_____

The above party may disclose this health information:

Address: Ohio Green Cards
106 Perkins Avenue,
Sandusky, Ohio 44870

Phone : (833) 420-6446

Fax:

Email: info@ohiogreencards.com

☐ - I authorize Ohio Green Cards to use my health information to determine if I qualify for the OMMCP Card.

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: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:
☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____