MADU MEDICAL GROUP

HIPAA AUTHORIZATION FORM

(Permission from patient/patient's legal guardian to share personal medical information)

Patient Name: _____ DOB: ____/____/____

Street Address: _____

City: _____ State: _____ Zip: _____

I,_____, hereby authorize Madu Medical Group P.C., and/or any medical facility to release any and all medical information and test results that pertain to me to the following individual(s):

Name:_____ Phone:_____ Relationship to patient: _____

Name:_____ Phone:_____ Relationship to patient: _____

Name:_____ Phone:_____ Relationship to patient: _____

I authorize Madu Medical Group P.C., or the medical facility to contact the individual(s) listed above to convey any pertinent information to me in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____

Signature of patient Date

_____ _____

Name of witness Date

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