



Affordable Telehealth Urgent Care & Chronic Disease Management

5473 Blair Rd Ste 100 #321964 Dallas, TX 75231 USA

Phone: 1-888-657-1856

Fax: 689-306-1634

Email: contactus@tangerinemed.com

Website: www.TangerineMed.com

HIPPA AUTHORIZATION FORM

1. I hereby authorize the use or disclosure of my protected health information as described below.

Individual: _____ ID Number: _____

Persons or organizations providing information: _____ Persons or organizations receiving information: _____

Description of information to be disclosed (including dates of service): _____

Describe the purpose or intended use of information: _____

(Note: "at the request of the individual" is adequate if the individual initiated authorization without a stated purpose.)

2. COMPLETE THIS SECTION IF HEALTHCARE PROVIDER REQUESTED AUTHORIZATION.

Healthcare provider: Will the healthcare provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes, ___ No ___

Individual: I understand that I get a copy of this form after I sign it. Initials: _____

3. **YES, YOU MAY DISCLOSE INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH: YES Initial:** _____ **NO, DO NOT Initial:** _____

4. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Initial: _____

5. I understand that this authorization will expire on the following date ___/___/___ (D/MM/YR) or with the following event: _____

6. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Initial: ___

7. Signature of patient or patient's representative _____

_____ Date

Printed name of patient's representative: _____

Relationship to the patient: _____

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Note that signature or initials are required in four places.

A copy of this completed, signed and dated form must be given to the Individual or other signatory.