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MEDISTOP CLINIC

HIPPA Authorization

Patient Name: _____ Date of Birth: ___/___/_____

Phone Number: _____ Date: _____

I, _____, hereby authorize MediStop Clinic, PA, its affiliates, its employees and agents to release/discuss my personal medical information with the following individuals:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

I understand that I have the right to revoke this authorization by providing a written notice to MediStop Clinic, PA. I further understand that this authorization is voluntary and that I may refuse to sign.

_____ At this time, I DO NOT want to authorize anyone other than myself/parent or guardian.

If a physician other than my personal physician requests my medical records, I understand a separate medical release form will be needed.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian's Signature Date