HIPAA Authorization for Use or Disclosure of Health Information

Please send records to REE Medical electronically or via fax:
Email: documents@reemedical.com
Fax: 760-284-7806

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.

Patient Name: _____

Date of Birth: _____ SSN: _____

I authorize the following using or disclosing party:

To use or disclose the following health information: (Check One)

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition:

_____

- ☐ My health information covering the period from _____ (date) to _____ (date)
- ☐ Other: _____

The above party may disclose this health information to the following recipient:

REE Medical

Phone: 888-495-8044
Fax: 760-284-7806
Email: documents@reemedical.com

Patient Signature: _____ Date: _____

If the patient is unable to sign, please list the reason:

_____

Signature of Authorized Representative:
_____Date: _____