MCHENRY COUNTY COLLEGE FITNESS CENTER

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

(HIPPA form)

By signing this authorization, I authorize (physician's name) ______________________

(address): ____

Patient Date of Birth: _______________________

To use and/or disclose certain protected health information (PHI) about me to:

Joel Chapman
Coordinator of Fitness Center
McHenry County College
8900 U.S. Highway 14
Crystal Lake, IL 60012
(815) 455-8599 Fax

This authorization permits __________________________ to use or disclose to MCC Fitness Center the following individually identifiable health information:

- MCC Physician Referral Form

This authorization will expire on: ____
(Expiration Date or Defined)

Information provided will not be disclosed to anyone outside the MCC Fitness Center. I have the right to revoke this authorization in writing.

Signed by: ___________________________ ___________________
Patient Signature Date

____
Print Patient Name

If patient is under 18 years old:

Signed by: ___________________________ ___________________
Parent or Guardian Signature Date

___________________________ ___________________
Print Parent or Guardian Name Relationship to Patient