Patient Privacy Authorization Form

Doctor Name ______________________ Practice Name ______________________

Patient Information

Full Name ______________________ DOB __________ Account # ______________________

Phone ______________________ Address ______________________

City ______________________ State __________ Zip __________

PCIHIPAA™
A Rectangle Health Company

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○ **Request a change to your PHI (Protected Health Information)**

In the section below, please tell us what information you are requesting to change and precisely what those changes should be. Provide as much detail as possible.

○ **Request a Restriction on Uses and Disclosures of your PHI**

Please provide detailed description of what and to whom the restriction applies to.

○ **Request an accounting of disclosures of your PHI**

Using the fields below, please tell us the time frame within which you are requesting an accounting of disclosures. If you are seeking an accounting of a certain type of disclosure or disclosures to a specific person or organization, please describe the disclosures for which you are seeking an accounting.

Begin Date: Date Field

End Date: Date Field

Date of Request

Signature