HIPAA Release Authorization

File: CB – HIPAA Release Authorization

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Specification of Healthcare Organization

I,_____, give my permission for

_____ to share the information listed in Section II of this document with:

Newpoint Partnership Inc
809 Monck St.
Brunswick, GA 31520
912-265-2940

I understand that Newpoint Partnership Inc may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section II – Health Information to be Shared

I give the healthcare organization specified in Section I permission to disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions. Disclosure may be via electronic copy, access via a web-based portal, or via hard copy.

Section III – Duration of Authorization
This authorization to share my health information is valid for 90 days from the signing of this authorization.

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to the healthcare organization specified in Section I.

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

- I do not need to give any further permission for the information detailed in Section II to be shared with Newpoint Partnership Inc.

Section IV – Signature

Signature: _____ Date: _____

Print your name: _____