Grand Valley Medical Specialists, P.L.C.

HIPAA FORM

Name:_____**DOB:**_____

I authorize GVMS to share my personal health information with the person(s) below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be disclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations.
I understand this consent will remain in effect until I cancel it in writing.

Name	Relationship to Patient	Phone	Authorization
			□ All □ Scheduling Only
			□ All □ Scheduling Only
			□ All □ Scheduling Only
			□ All □ Scheduling Only

☐ **I do not authorize the release of my medical information to anyone.**

Patient/Guardian Signature:_____

Date: _____