Family Medicine Associates
Westfield, Massachusetts

HIPAA AUTHORIZATION FORM

I, _____, give permission to Family Medicine Associates to:

Disclose health information to:

Name: _____

Relationship: _____

Information to be disclosed (check all that apply):

- ☐ Medical Information
- ☐ Treatment Information
- ☐ Diagnostic Results
- ☐ Other: _____

You may revoke this authorization in writing at any time by sending written notification to Family Medicine Associates at 75 Springfield Road, Suite 1, Westfield, Ma. 01085.

Your notice will not apply to actions taken by the person named above prior to the date your written request to revoke authorization is received.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

SIGNED BY: _____ DATE: _____
Patient Signature

_____ _____
Print Patient's Name Patient's Date of Birth