**HIPAA RELEASE OF INFORMATION AUTHORIZATION**

 **Consent for access to Protected Health Care Information:**

 I give consent to the staff at Bautista Medical Group/ LipsByMatt to communicate with the person(s) listed below regarding my medical treatment. I consent to the use of my protected Health Care Information when communicating with the person(s) below. Bautista Medical Group/ LipsByMatt may communicate in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Bautista Medical Group/ LipsByMatt in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST NAMES OF PERSONS OR FAMILY

YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU:

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_