HIPAA Authorization Form

I authorize the following individuals to have full access to my health information:

_____	_____	_____
Print Name	Relationship	Date
_____	_____	_____
Print Name	Relationship	Date

I, _____ give my permission for you to leave any medical/lab information for me at the following phone numbers:

Home #: _____

Mobile #:_____

Work #: _____

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____ have received a copy to Young Minds Psychiatry

_____	_____
Signature of Patient or Guardian	Date