HERITAGE
Counseling and Wellness
PLLC

www.heritagecw.com
910.240.4599

HIPAA Authorization Form

Please complete this form to indicate your preference for how you would like your Protected Health Information (PHI) to be shared.

Client's Name: _____

DOB: _____

Please select one of the following options:

_____ Check here if you only want your Protected Health Information (PHI) to be shared with the parties listed in the Notice of Privacy Practices Form.

_____ Check here if you want your Protected Health Information (PHI) to be shared with the parties listed in the Notice of Privacy Practices Form and additional persons indicated below.

Name	DOB	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Client (or Client's Guardian or Agent) Date