

HIPAA Authorization Form

Purpose: This form provides authorization for the use and disclosure of protected health information (PHI) related to Hyperbaric Oxygen Therapy (HBOT) and LiveO2 units.

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Zip Code: _____

City: _____ State: _____

Phone Number: _____ Email Address: _____

I, _____ authorize the use and disclosure of my protected health information (PHI) for the purpose of administering and managing Hyperbaric Oxygen Therapy (HBOT) and LiveO2 units. This authorization includes but is not limited to the following:

- 1. Treatment and Services:** I authorize the healthcare provider or authorized personnel involved in my HBOT and LiveO2 sessions to access and use my PHI to provide treatment, services, and related healthcare activities.
- 2. Consultation and Coordination:** I authorize the sharing of my PHI among healthcare professionals and entities involved in my care for consultation, coordination, and continuity of services related to HBOT and LiveO2 treatments.
- 3. Billing and Insurance:** I authorize the release of my PHI to facilitate billing and insurance claims related to HBOT and LiveO2 services provided to me. This includes sharing information with insurance companies, billing agencies, and related entities for reimbursement purposes.
- 4. Research and Education:** I authorize the use of my de-identified PHI for research, educational, or statistical purposes related to HBOT and LiveO2, ensuring my identity remains anonymous.

This authorization is valid for the duration of my treatment involving HBOT and LiveO2 services unless revoked by me in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization.

I acknowledge that my healthcare provider has provided a Notice of Privacy Practices outlining how my PHI may be used and disclosed, and I have been given an opportunity to review this document.

Patient's Signature: _____

Date: _____

Witness (if applicable): _____

Relationship to Patient (if signing for patient): _____