Papillon Center HIPAA Authorization Form

I authorize Papillon Center (PGWC) access to my medical/health information in order to further my treatment.

Legal name:_____

Gender Preferred Name: _____

SS#_____ DOB:_____/_____/_____

I give permission to Papillon Center to disclose and/or discuss my health information with the following:

(Please list all of your providers, doctors, mental health professionals and any individuals such as friends or family members)

If you do not want your TG status to be known/discussed be sure to indicate this

_____

Information to be disclosed/discussed:

Medical Records	**Alcohol/Drug Abuse**
Diagnostic Records	**Aids/HIV related information**
Treatment Codes	**Psychological or Psychiatric Conditions**

This document is concerning individuals only. Nothing will be discussed with your insurance company unless you approve otherwise.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment. You may inspect or copy the protected health information to be used or disclosed under this authorization. Finally you may revoke this authorization in writing at any time by sending a written notification to Papillon Gender Wellness Center.

Patient Signature _____ Date _____

Patient Legal Name _____

Person Authorized to sign for Patient _____