

HIPAA Authorization Form for Data Transfer

Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, _____, hereby authorize Trigram Software, LLC to view the information in my AcuBase database for the express and sole purpose of transferring data to a new, upgraded database. I understand that the data and related private health information of those within the database will be kept private and absolutely confidential, and that the data will be used for no other purposes beyond those already stated above.

This authorization shall be in force and effect until the data has been returned in the upgraded database, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization at any time by sending such written notification to Trigram Software, LLC at support@trigram.com, and/or 6114 La Salle Ave. #230, Oakland, CA 94611.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature of Representative of Medical Practice

Description of Personal Representative's Authority

Date