HIPAA Authorization for Release of Health Information

Patient Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____

Information to be Disclosed

I hereby authorize the release of the following protected health information (PHI):

☐ Complete Medical Record
☐ Specific Records (please specify): _____
☐ Billing Records
☐ Other: _____

Purpose of Disclosure

This information is being disclosed for the following purpose(s):

☐ Continuity of Care
☐ Insurance / Payment
☐ Legal
☐ Personal Use
☐ Other: _____

Disclosure To / From

To / From (Name/Organization): _____
Address: _____
Phone: _____ **Fax:** _____

Expiration

This authorization will expire:

☐ On the following date: _____
☐ One year from the date of signature
☐ Other: _____

Patient Rights

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it.
- I understand that this authorization is voluntary and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon signing this form.
- I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Signatures

Patient / Legal Representative: _____
Date: _____

If Legal Representative, Relationship to Patient: _____

Witness (if required): _____
Date: _____