HIPAA Authorization for Release of Health Information

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Purpose of Release:

I, _____, authorize the release of my health information to the individuals listed below for the purpose of sharing information related to my medical care, including diagnosis, making appointments, treatment, prognosis, and other relevant details.

Individuals Authorized to Receive Information:

1.Name: _____
Relationship: _____
Phone: _____

2.Name: _____
Relationship: _____
Phone: _____

3. Name: _____
Relationship: _____
Phone: _____

This authorization permits the release of the following health information (select or specify applicable information):

- [ ] Entire medical record
- [ ] Specific medical conditions, treatments, or procedures:
_____
- [ ] Mental health records
- [ ] Substance abuse treatment records
- [ ] HIV/AIDS information
- [ ] Billing and payment information

Expiration of Authorization:

This authorization shall expire (check one):

- [ ] Upon termination of treatment with [Health Care Provider/Organization Name]
- [ ] One year from the date of signature
- [ ] Other (Specify): _____

Revocation:

I understand that I may revoke this authorization at any time by submitting a written request to the health care provider or organization listed below. The revocation will not apply to any information already disclosed under this authorization.

I hereby authorize the release of my health information as described above.

Signature of Patient (or Legal Representative): _____

Date: _____

Printed Name of Patient (or Legal Representative): _____

Witness Signature (Optional): _____

Date: _____

Health Care Provider/Organization Receiving this Authorization

Name: _____

Contact Information: _____