# HIPAA Authorization Form

## Patient Medical Information Release

Patient Full Name

Date of Birth

Address

Phone Number

Healthcare Provider or Facility Authorized to Release Information

Recipient of Information (Person/Organization to Receive Records)

Information to be Released (check all that apply)

e.g., All medical records, Lab results, Imaging reports, Billing, Other (specify)...

Purpose of Release

e.g., Continuity of care, Personal, Legal, Insurance, Other

Effective Date of Authorization

Expiration Date of Authorization

**By signing below, I authorize the release of my protected health information as described above. I understand:**

- This authorization is voluntary.
- I may revoke this authorization at any time in writing.
- Revocation will not apply to information already released pursuant to this authorization.
- Information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy law.
- Refusing to sign will not affect my treatment, payment, enrollment, or eligibility for benefits.

Patient Signature

Date

Representative Signature (if patient is a minor or unable to sign)

Relationship to Patient

If you have questions about this authorization, contact your healthcare provider.