HIPAA Authorization for Electronic Health Information Transfer

I hereby authorize the electronic transfer of my health information as described below.

Patient Information

Full Name:

Date of Birth:

Address:

Recipient/Receiving Facility

Name or Organization:

Address:

Email (for electronic delivery):

Information to be Released

- All medical records
- Lab and test results
- Imaging and radiology reports
- Other (please specify): _____

Purpose of Disclosure

e.g., Continuity of care, personal use, insurance, etc.

Authorization and Expiration

I understand that:

- This authorization is voluntary and I may revoke it at any time in writing.
- Information disclosed may no longer be protected by federal privacy regulations once released.

- This authorization will expire one year from the date signed unless otherwise specified below:

  Specify alternative expiration date:

  _____

  Signature of Patient or Legal Representative

  (Type full name if signing electronically)

  _____

  Date

  If signed by Legal Representative, state relationship to patient:

  _____

  You are entitled to a copy of this authorization after signing.