Authorization for Release of Health Information (HIPAA-Compliant)

Patient Name:

_____

Date of Birth:

_____ Phone Number: _____

Address:

_____

Release Records From (Name/Facility & Address):

_____

Release Records To (Recipient Name/Facility & Address):

_____

Information to be disclosed (check all that apply):

- ☐ All medical records
- ☐ Labs and test results
- ☐ Treatment summaries
- ☐ Other (please specify): _____

Purpose of Disclosure:

- ☐ Continued care
- ☐ Insurance
- ☐ Personal use
- ☐ Other (please specify): _____

Dates of Service to be disclosed (if applicable):

_____ to _____

Note: This authorization may include information pertaining to mental health, substance use, HIV/AIDS, genetic testing, and other sensitive conditions unless otherwise specified.

Expiration Date or Event:

_____

Your Rights:
- You may revoke this authorization in writing at any time except to the extent that disclosure has already occurred.
- A photocopy or facsimile of this authorization is as valid as the original.
- Refusing to sign will not affect your ability to obtain treatment, payment, or eligibility for benefits.

Signature of Patient (or Authorized Representative):

_____

Date:

_____ Relationship to patient (if other than self): _____