HIPAA Consent Form for Third-Party Information Sharing

I, the undersigned, hereby authorize [Healthcare Provider or Organization] to disclose and release my protected health information as described below to the following third party.

Patient Name

Date of Birth

MM/DD/YYYY

Name of Third Party (Person/Organization)

Information to be Disclosed

E.g., All medical records, specific test results, etc.

Purpose of Disclosure

E.g., Coordination of care, insurance, legal, etc.

Authorization and Rights

- I understand that I have the right to revoke this consent at any time by submitting a written request.
- I acknowledge that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether I sign this authorization.

This authorization will remain in effect until (check one):

☐

[ ] Upon fulfillment of the purpose stated above

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[ ] Expiration date: MM/DD/YYYY

Patient Signature

Date

MM/DD/YYYY

If signed by representative, print name

Relationship to Patient