HIPAA Patient Information Release Authorization Form

Patient Name:

Date of Birth:

Phone Number:

Address:

Release Information To:

Name/Organization:

Address:

Phone:

Fax (if applicable):

Information to be Released

☐ All Medical Records ☐ Lab/X-Ray/Imaging Reports ☐ Billing Records ☐ Other:

Purpose of Disclosure

ex: Continuation of care, insurance, etc.

Expiration Date or Event

ex: One year from today, or specify date/event

Patient Rights & Authorization

I understand that:
- I may revoke this authorization in writing at any time.
- I am not required to sign this form to receive health care treatment.
- Information disclosed may be subject to re-disclosure by the recipient.

Patient/Representative Signature:

_____

Date:

_____

If signed by other than patient, state relationship and authority: