HIPAA AUTHORIZATION FORM

FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Social Security #:** _____

_____

_____ **Phone Number:** _____

Date(s) of Service for requested information: _____

I hereby authorize (name and address of hospital/doctor's office that created the medical records):

_____

_____

_____

To release my medical records to (complete name, address and contact information):

_____

_____

_____

Please release the following information in my medical record (check all that apply):

o History & Physical	o Emergency Room Record	o Entire Medical Record
o Consultation Report(s)	o Laboratory Report(s)	o Other: _____
o Discharge Summary	o X-Ray/Imaging Report(s)	o _____
o Operative Report(s)	o Abstract or Summary	o _____

Please release the following information in my medical record (check all that apply):

I o do o do not want HIV/AIDS information released under this authorization.

I o do o do not want mental health information released under this authorization.

I o do o do not want drug/alcohol abuse or treatment information released under this authorization.

I o do o do not want genetic testing information released under this authorization.

I o do o do not want sexually transmitted disease information released under this authorization.

The purpose for release of the above information is for:

o Continuation of Care o Insurance o Legal o At my request (patient only) o Other: _____

This authorization will expire within one (1) year unless otherwise indicated. I understand that this authorization is voluntary and may be revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization.
I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization of this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

PLEASE PROVIPE A COPY OF PHOTO IDENTIFICATION WITH THIS RELEASE FORM

_____ o Parent

Signature of Patient or Patient's representative o Personal Representative

(Personal & Legal Representative must include proof of status) o Legal Representative

_____

Date

_____

Witness

FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL BE RETURNED