

**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):**

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

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

- I  do  do not want HIV/AIDS information released under this authorization.
- I  do  do not want mental health information released under this authorization.
- I  do  do not want drug/alcohol abuse or treatment information released under this authorization.
- I  do  do not want genetic testing information released under this authorization.
- I  do  do not want sexually transmitted disease information released under this authorization.

**The purpose for release of the above information is for:**

- Continuation of Care
- Insurance
- Legal
- At my request (patient only)
- 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 PROVIDE A COPY OF PHOTO IDENTIFICATION WITH THIS RELEASE FORM**

\_\_\_\_\_  
**Signature of Patient or Patient's representative**  
(Personal & Legal Representative must include proof of status)

Parent  
 Personal Representative  
 Legal Representative

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

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