HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Patient Information

Full Name: ____
Social Security Number: ______________ **Date of Birth:** ______________
Address: ____
____
Phone Number: ____________________
Email Address: ____

1. The following specific person(s) or class of persons or facility is authorized to make the requested use or disclosure:
   ____
   ____

2. I, ____________________, hereby authorize the use or disclosure of protected health information concerning myself to the following person(s) or class of persons:
   ____
   ____

3. I also request that the Medical Records be released to the following:

   Organization/Individual's Name: ______________________________
   Address: ____
   ____
   Phone Number: ______________ **Fax Number:** ______________

   Organization/Individual's Name: ______________________________
   Address: ____
   ____
   Phone Number: ______________ **Fax Number:** ______________

4. The specific information that should be disclosed is all medical records, treatments, x-rays, diagnostic laboratory test results, progress notes, and any other similar medical records on me.

Other:____

____

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

6. I may hereby revoke this authorization by notifying __________________________ in writing of my desire to revoke it. However, I do understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that my refusal to sign will not affect my ability to obtain treatment from or the payment to the medical provider to whom this authorization is furnished.

7. The purpose of the requested use or disclosure is at the request of the individual patient.

8. I ask that the Medical Records be released within the next thirty (30) days as required by the Health Insurance Portability and Accountability Act ("HIPAA")

9. This release will be valid until _______________________, or until written notice is sent by me therefore revoking the release before the aforementioned end date.

_________________________________ _______________________

Signature of Patient/Claimant **Date**

-or-

Authorized Representative of the above-referenced Patient:

Full Name: ___________________________

_________________________________ _______________________

Signature of Authorized Representative **Date**