HIPAA Authorization Form

Name: _____ Address: _____

City, State, ZIP Code: _____ Email address: _____

Phone number: _____ Date: _____ dd / mm / yyyy

Recipient's name: _____ Recipient's address: _____

City, State, ZIP Code: _____

I, _____ hereby authorize the release of my protected health information (PHI) as described below, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

PATIENT INFORMATION:

Full Name: _____ Date of Birth: _____ dd / mm / yyyy

Address: _____ City, State, ZIP Code: _____

Phone Number: _____ Email Address: _____

RECIPIENT INFORMATION:

Full Name/Entity Name: _____ Address: _____

City, State, ZIP Code: _____ Phone Number: _____

Email Address: _____

Purpose of Disclosure

Description of Information to Be Disclosed

Persons Authorized to Make Disclosure

Persons Authorized to Receive Disclosure

Duration of Authorization

Right to Revoke Authorization: I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization. Revocation of this authorization should be submitted in writing to the recipient listed in Section 2 of this form.

Acknowledgment of Understanding: I have read and understood the contents of this HIPAA Authorization Form, and I voluntarily sign it, knowing the purpose and consequences of authorizing the disclosure of my protected health information.

Patient's Signature

Date: _____ dd / mm / yyyy

Healthcare provider's Signature

Date: _____ dd / mm / yyyy **Witnessed by:** _____

Date: _____ dd / mm / yyyy

Witness's Signature

Consent for Electronic Signature: By signing this form electronically or by any means of electronic communication, I acknowledge and agree that my electronic signature is legally binding and has the same force and effect as a traditional handwritten signature.

Patient's Signature

Date: _____ dd / mm / yyyy