HIPAA Medical Release Form

Patient's name: _____ **Date of birth:** _____ dd / mm / yyyy

Address:

Social security number: _____

MEDICAL RECORDS

Fill up the following:

Select one:

- ◯ All medical records. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA privacy regulations. (Specify restrictions on the right
- ◯ Specific medical records (specify)

Restrictions: Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall:

◯ be included ◯ NOT be included

Specify medical records:

RECIPIENT

My medical records shall be disclosed to the following individual or entity:

Name: _____ **Contact:** _____

Address:

Phone: _____ **E-mail:** _____

Fax: _____

PURPOSE OF RELEASE

Select one:

◯ At request of individual ◯ Other

EXPIRATION

This authorization expires on: _____ dd / mm / yyyy

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

I will receive a copy of this authorization after I have signed it.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

Signature:

Printed name: _____ **Date:** _____ dd / mm / yyyy

FOR OFFICE USE ONLY

Request received by: _____ **Date processed:** _____ dd / mm / yyyy

Processed by: _____