HIPAA Release Form Massachusetts

Fill up the following

SECTION I

Fill up the following

SECTION II

A. Health and personal information

Fill up the following

Please include any dates and details you want to share

B. Permission for specific health information

Only if you choose to share any of the following information:

Please write your initials: _____

SECTION III – REASON FOR SHARING THIS INFORMATION

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request" if you are initiating the request

SECTION IV – WHO MAY SHARE THIS INFORMATION

I give permission to the person or organization listed below to share the information I listed in Section II:

Name: _____ Organization: _____

Address: _____

SECTION V – WHO MAY RECEIVE MY INFORMATION

The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

Name: _____ Organization: _____

Address: _____

SECTION VI – HOW LONG THIS PERMISSION LASTS

Fill up the following

SECTION VII – SIGNATURE

Please sign and date this form, and print your name.

_____

Your signature

Date: _____ dd / mm / yyyy **Print your name:** _____

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court-appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form:

_____

Signature of the person filling out this form

Describe how this person has legal authority for this individual