AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 CFR 164.508 (HIPAA)

Must be filled in COMPLETELY

TO: _____
(Name & address of Provider / Drs. office)

Patient Name: _____ Date of Birth: _____

Address: _____ Soc. Sec. #: _____

_____ Phone: _____

I, _____, authorize you to release the following protected health information.

- Any and all inpatient admissions, all ER visits, outpatient clinic notes, diagnostic testing, consults, doctors orders, progress notes, social service records, reports, correspondence, consultations, memoranda, history, discharge summaries, medical summaries, diagnoses, history, records received from other medical offices and/or any writing of any kind. **This may include Mental Health/Psychiatric information, Drug and/or Alcohol information, Sexually Transmitted Disease information or HIV/AIDS information, if applicable.**
- Anything to be excluded is as follows: _____
_____

This protected health information is being disclosed for the following purpose(s): _____
_____. (continued care, litigation, insurance, etc.)

You are authorized to release the above records to the following: (Must have **COMPLETE** address for copies to be sent)

_____
Name of Representative (Where you want the records to go)

_____
Street Address

_____
City, State and Zip Code

This authorization shall be in force and effect until _____ at which time this authorization expires. If this space is left blank, this authorization will expire in one (1) year.

*A photocopy of this authorization shall be as valid as the original.
*I understand this disclosure may involve remuneration to the doctor's office or their representative.
*I have the right to revoke this authorization by sending written notification to the above named healthcare provider, Attention - Privacy Officer. I understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information.

*I understand that I have the right to:

- Inspect or copy the individually identifiable health information to be disclosed (May be a fee)
- Refuse to sign this authorization. (There is no penalty for refusal to sign & treatment will not be determined by it)
- A photocopy of this authorization
- I understand the recipients may redisclose information I have authorized them to receive & it may no longer be protected by HIPAA.

_____
Signature of Patient or Personal Representative

_____
Date (MUST be dated)

_____
Name of Patient or Personal Representative (Please print)

_____
Description of Personal Representative's Authority to Sign for Patient (Attach documents to show Authority e.g.: POA, Death certificate, etc.) MUST HAVE if applicable