HIPAA Release & Authorization Form

Authorize the release or disclosure of your Protected Health Information (PHI) to a designated person, provider, or organization. Please complete all required sections to ensure your request is processed in compliance with HIPAA regulations.

Patient Information

Please provide your personal information as the patient authorizing this release.

Full Name *

Date of Birth (MM/DD/YYYY) *

Phone Number *

Email Address *

Address *

Person/Organization Authorized to Receive Records

Enter the details of the person or organization authorized to receive your PHI.

Recipient Name *

Relationship to Patient *

Recipient Phone Number *

Recipient Fax Number (optional)

Recipient Email Address *

Recipient Address *

Provider/Facility Authorized to Release Records

Provide the information for the clinic, provider, or facility authorized to release your PHI.

Clinic/Provider/Facility Name *

Provider Phone Number *

Provider Fax Number (optional)

Provider Address *

Description of Information to Be Released

Select the types of Protected Health Information (PHI) to be released.

Please select the types of PHI to be released *

- ☐ Medical Records
- ☐ Lab Results
- ☐ Imaging/Radiology Reports
- ☐ Billing/Payment Information
- ☐ Visit/Appointment History
- ☐ Discharge Summary
- ☐ Other

If 'Other', please describe the information to be released

Sensitive Information Authorization

Certain types of PHI require additional authorization. Please indicate if you authorize the release of any of the following:

I authorize the release of the following sensitive information (if applicable):

- ☐ HIV/AIDS-related information
- ☐ Mental/Behavioral Health Records
- ☐ Substance Use Disorder Records
- ☐ Genetic Testing Information
- ☐ Sexually Transmitted Disease (STD) Information

I acknowledge that I am authorizing the release of sensitive information as indicated above. *

☐ I acknowledge and authorize the release of sensitive information as indicated above.

Purpose of Disclosure

State the purpose for which your PHI is being disclosed.

Purpose of Disclosure *

- ◯ Continuing Care
- ◯ Legal
- ◯ Insurance
- ◯ Personal Use
- ◯ Other

If 'Other', please specify the purpose of disclosure

Method of Disclosure

Choose how you want your PHI to be disclosed.

Preferred Method of Disclosure *

- ◯ Mail
- ◯ Fax
- ◯ Email
- ◯ In Person Pickup

Expiration of Authorization

Specify when this authorization will expire.

This authorization will expire: *

- ◯ One year from the date of signature
- ◯ Upon completion of the purpose stated above
- ◯ On a specific date (please specify below)

If 'On a specific date', please enter the date (MM/DD/YYYY)

Patient Rights & Revocation Notice

Please review and acknowledge your rights regarding this authorization.

Acknowledgments (please check all that apply): *

- ☐ I understand that I have the right to revoke this authorization at any time by submitting a written request to the provider/facility listed above.
- ☐ I understand that refusing to sign this form will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- ☐ I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- ☐ I have received a copy of this signed authorization if requested.

Signature Section

Please sign and date to complete this authorization.

Name of Patient or Legal Representative *

If signed by a Legal Representative, state your authority to act for the patient

Date Signed (MM/DD/YYYY) *