HIPAA Medical Records Release Authorization Form

Please complete all sections of this authorization form to facilitate the release of protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

1. Patient Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Social Security Number (Last 4 digits): _____

Phone Number: _____

Email Address: _____

Mailing Address: _____

2. Entity Releasing the Medical Records

Identify the provider, hospital, or clinic authorized to release the records.

Organization/Provider Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

3. Entity Receiving the Medical Records

Identify the person or organization authorized to receive the records.

Organization/Recipient Name: _____

Attention To (if applicable): _____

Address: _____

Phone Number: _____

Fax Number: _____

4. Information to be Disclosed

Specify the health information you authorize to be released (e.g., "All medical records", "Lab reports only", or specific dates of service).

Description of Information to Release: _____

Specific Dates of Service (e.g., From MM/DD/YYYY to MM/DD/YYYY): _____

5. Purpose of Disclosure

Specify the purpose for this request (e.g., "Personal Use", "Legal Claim", "Continuing Care", "Insurance Application").

Purpose of Release: _____

6. Expiration and Revocation

This authorization will automatically expire one year from the date of signing unless a specific date or event is written below.

Specific Expiration Date or Event (Optional): _____

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 in reliance on this authorization.

7. Patient Authorization and Signature

By signing below, I authorize the release of my protected health information as described above.

Patient Printed Name: _____

Patient/Authorized Representative Signature (Sign after printing): _____

Date of Signature (MM/DD/YYYY): _____

If Personal Representative, state relationship to patient: _____