

Patient HIPAA Privacy Authorization Form

This form authorizes the disclosure and use of protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Address:

2. Authorization to Disclose

I hereby authorize the following entity to release my protected health information:

Authorized Entity/Facility Name:

3. Recipient of Information

Please disclose my protected health information to the following individual or organization:

Recipient Name/Organization:

Recipient Address:

4. Scope of Information to Be Disclosed

Specify the health information you authorize to be released (e.g., "All medical records", "Lab results from January 2023", etc.):

5. Purpose of Disclosure

Specify the purpose of this disclosure (e.g., "At the request of the individual", "Continuing medical care", "Legal matter", etc.):

6. Expiration of Authorization

This authorization will expire on the following date or event (e.g., "One year from today", "End of litigation", etc.):

Expiration Date/Event:

7. Acknowledgment and Signature

By signing below, I understand that my authorization is voluntary. 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. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Printed Name of Patient or Personal Representative:

If Personal Representative, state relationship to Patient:

Signature of Patient or Representative (Sign on line):

Date (MM/DD/YYYY):

