HIPAA Authorization for Release of Electronic Health Records

This form authorizes the disclosure and use of protected health information in accordance with HIPAA regulations. Please fill out all fields completely before printing and signing.

1. Patient Information

Patient Full Name:	
Date of Birth (MM/DD/YYYY):	
Street Address:	
City, State, Zip:	
Phone Number:	
Medical Record Number (if known):	

2. Entity Authorized to Release Records

I hereby authorize the following organization/facility to release my electronic health records:

Organization Name:	
Address:	
Phone/Fax:	

3. Entity Authorized to Receive Records

Please disclose my electronic health records to the following individual or organization:

Recipient Name/Organization:	
Address:	
Phone/Fax:	

4. Description of Electronic Health Records to be Disclosed

Specify the records you wish to release (for example: "All EHR records", "Billing records only", or "Records from MM/DD/YYYY to MM/DD/YYYY"):

5. Purpose of Disclosure

Specify the purpose of this disclosure (for example: "At the request of the individual", "Legal claim", "Continuing care", or "Insurance evaluation"):

6. Expiration Event or Date

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

Expiration Date/Event:

7. Patient Understandings and Rights

- 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 the information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

- I understand that my treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on my signing this authorization.

8. Signature and Date

To be signed by the patient or authorized personal representative after printing.

Printed Name of Patient/Representative:	
Relationship to Patient (if Personal Representative):	
Signature of Patient or Representative:	_____
Date of Signature (MM/DD/YYYY):	