HIPAA Authorization Form

Name: ____

Address: ____

City, State, ZIP Code __________________________________

Email address: ______________________________________

Phone number: _____________________________________

Date: ____

Recipient's name: _____________________________________

Recipient's address: __________________________________

City, State, ZIP Code: __________________________________

Dear_____________________________,

I, _____________________hereby authorize the release of my protected health information (PHI) as described below, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

1. **Patient Information:**

Full Name: ____

Date of Birth: ____

Address: ____

City, State, ZIP Code: _______________________________________

Phone Number: ____

Email Address: ____

2. **Recipient Information:**

Full Name/Entity Name: ______________________________________

Address: ____

City, State, ZIP Code: _______________________________________

Phone Number: ____

Email Address: ____

3. **Purpose of Disclosure:** ____

____

4. **Description of Information to Be Disclosed:** _____________________________

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5. **Persons Authorized to Make Disclosure:** ________________________________

____

6. **Persons Authorized to Receive Disclosure:**______________________________

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7. **Duration of Authorization:** ____

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8. **Right to Revoke Authorization:** 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 based on this authorization. Revocation of this authorization should be submitted in writing to the recipient listed in Section 2 of this form.

9. **Acknowledgment of Understanding:** I have read and understood the contents of this HIPAA Authorization Form, and I voluntarily sign it, knowing the purpose and consequences of authorizing the disclosure of my protected health information.

Patient's Signature: ___________________________ Date: _________________________

Healthcare provider’s Signature: ___________________________ Date: ___________________

Witnessed by: ___________________________ Date: ___________________

Witness’s Signature:____

10. **Consent for Electronic Signature:** By signing this form electronically or by any means of electronic communication, I acknowledge and agree that my electronic signature is legally binding and has the same force and effect as a traditional handwritten signature.

Patient's Signature: ___________________________ Date: _______________