

HIPAA Medical Release Form

Patient's name:	
Date of birth:	Social security number:
Address:	
Medical records	
I hereby authorize _____ ("Releasor") to use or disclose the following:	
<p>All medical records. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA privacy regulations.</p> <p><u>Restrictions:</u> <i>Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall:</i></p> <p><i>be included.</i></p> <p><i>NOT be included.</i></p>	
Specific medical records:	
Recipient	
My medical records shall be disclosed to the following individual or entity :	
Name:	E-mail:
Phone:	Fax:
Contact:	
Address:	
Purpose of release	
Select one:	
At request of individual	
Other:	

Expiration

This **authorization** expires on:

I understand that signing this **authorization** is voluntary and that my **treatment, payment, enrollment** in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this **authorization**.

I understand that I have the right to revoke this **authorization** at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this **authorization** may be subject to **re-disclosure** by the recipient and may no longer be protected by **HIPAA privacy** regulations. I will receive a copy of this **authorization** after I have signed it.

Patient or legal representative signature

Signature:

Printed name:

Date:

For office use only

Request received by:

Date processed:

Processed by: