HIPAA Release Form

Full name: _____

Date of birth: _____ **Gender:** _____

Address: _____

Contact information: _____

I, _____, hereby authorize the release of my protected health information (PHI) as described below:

1. **Purpose of release**

2. **Information to be released**

3. **Recipient(s) of information**

4. **Duration of authorization:** _____

5. **Revoke authorization:** I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must provide a written request to the releasing party.

6. **Potential risks:** I acknowledge that the released information may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

7. **Rights:** I understand that I have the right to refuse the release of my protected health information. I also understand that the refusal to sign this authorization will not affect my ability to obtain treatment, payment, or eligibility for benefits.

8. **Signature:** By signing below, I acknowledge that I have read and understood the contents of this authorization form. I authorize the release of my protected health information as described above.

_____ _____

Patient's signature **Date**

_____ _____

Healthcare provider's signature **Date**

_____ _____

Witness' name and signature (if applicable) **Date**