Release of Information Form

Patient Information				
First Name	Last Name	Date of Birth	Gender	
Address		City	State	Zip Code
Email		Contact Number		

I. Authorization

I authorize the following named individual or organization,

Authorized Person/Organization

Person/Organization Name		Contact Number
Address		
City	State	Zip Code

to use or disclose the following information related to the above named patient:

- ☐ All Medical Information
- ☐ Only Medical Information Related to ___________________________
- ☐ Medical Information from __/__/____ to __/__/____
- ☐ Other: ___________________________

for the purposes of

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Insurance Claims
- ☐ Legal Proceedings
- ☐ Employment
- ☐ Other: ___________________________

II. Disclosure

I authorize this information to be shared with

Receiving Person/Organization

Person/Organization Name		Contact Number
Address		
City	State	Zip Code

Patient Information

First Name	Last Name	Date of Birth	Gender

III. Expiration

This authorization is valid until

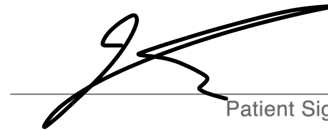
☐ Authorization is revoked through written notice to the authorized person or organization
☐ The following date __/__/____
☐ Other: ____

IV. Statements of Rights

- I understand that I have the right to revoke this authorization, in writing to the authorized person or organization, and at any time, except where uses or disclosures have already been made based upon my original permission.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand I may not be able to revoke this authorization if the purpose was to obtain insurance.
- I understand that it is possible that information disclosed under the terms of the authorization may be re-disclosed by a recipient and no longer protected by HIPAA privacy standards.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether the individual signs the authorization
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature Authorization

Patient Signature



______________________________ Patient Name (Printed)

______________________________ Patient Signature

______________________________ Date

Representative Signature

______________________________ Representative Name (Printed)

Authority to act on behalf of patient

☐ Parent of Minor ☐ Guardian ☐ Other: ______________________________

______________________________ Representative Signature

______________________________ Date

______________________________ Minor Individual Signature (If Applicable)

______________________________ Date