**Sample Patient Authorization to Release Medical Information**

**Patient Information**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release Information**

I hereby authorize:

Name of Facility/Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release my medical records to:

Name of Person/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Disclosure (check one):**

[ ] Continuing Medical Care

[ ] Legal Purposes

[ ] Insurance

[ ] Personal Use

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be Released (check all that apply):**

[ ] All Medical Records

[ ] Lab Results

[ ] Radiology/X-ray Reports

[ ] Medication List

[ ] Immunization Records

[ ] Consultation Reports

[ ] History & Physical

[ ] Operative Reports

[ ] Drug, Alcohol Use/Treatment

[ ] Communications with Psychiatrists or Psychologists

[ ] Sexually Transmitted Diseases

[ ] Genetic Testing/Results

[ ] Billing Records

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates of Service to Release:**

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**Records Delivery (select one)**

[ ] Paper:

\_\_\_\_Mailed to address on this Authorization.

\_\_\_\_ Pick up by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Electronic:

\_\_\_\_Faxed to number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_CD (mailed only to address on this Authorization)

\_\_\_\_Email to address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization and Signature**

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary and that I may revoke it at any time as outlined below.

* Right to Revoke: You may revoke this authorization in writing at any time, except to the extent that action has already been taken based on it. Instructions for revocation are available in our Notice of Privacy Practices.
* Conditioning of Services: Your treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization, unless permitted by law and specifically stated.
* Redisclosure Risk: Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

If signed by a Legal Representative, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (if required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_