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Patient Authorization for Disclosure of Health Information

*This form is for covered entities who must comply with HIPAA law.

Patient Name: ____Date of Birth: ______/______/_______
Address: ___________________________________ City: ___________________________State: ___ Zip: ______
E-mail Address: ____Phone:_____________________________

I request that my protected health information (PHI) from [healthcare provider] be disclosed to:
Recipient name:____
Address: ___________________________________City: ___________________________State: ___Zip:_______
E-mail Address: ____Phone:_____________________________
Fax (healthcare provider only): ____

- I authorize the following PHI to be released from my medical record(s):
- Entire Record
- Treatment Progress
- Diagnosis
- Test Results
- ____
- Dates of Treatment
- Session Start/Stop Times
- Treatment Plan or Goals
- Prognosis
- Other (please specify):

Covering the period of healthcare from: ______________to _______________

Purpose for disclosure of information:

____

Disclosure Format (Paper is default if not marked):
_______US Mail (paper format) _______Fax(healthcare provider only) _______E-mail (secure format)
_______ E-mail (unsecure format, i.e., Gmail, Yahoo) _______CD/Flash drive – secure format _______Other (please specify below) ____

By signing this authorization form, I understand that:
• Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law.
• I have the right to REVOKE this authorization at any time. Revocation must be made in writing and presented or mailed to:

[ADDRESS]____

Revocation will not apply to information that has already been disclosed in response to this authorization.

• Unless otherwise revoked, this authorization will EXPIRE on the following date/event/condition:

____

_______ If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.

• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

• Any disclosure of information carries with it the potential for unauthorized redisclosure.

• I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

____________________________________ ________________________________

Signature of Patient or Authorized Representative Relationship to Patient (if applicable)

____ _________________________________

Print Name Date