HIPAA Records Release Form

This form is for use when such authorization is required and complies with the HIPAA Standards.

I. Patient Information

Full Name: _____
Date of Birth: _____
Address: _____
City, State, ZIP: _____

II. The releasing Party

The patient, or their authorized representative, authorize(s) _____to release and disclose the protected health information described below.
Name/Facility: _____
Phone: _____ Fax: _____

III. The recipient

Name: _____
Address: _____
Phone: _____

IV. Description of Information to Be Released

The authorization covers the entire patient's health records including financial records, mental healthcare, communicable diseases, etc.

V. Purpose of Disclosure

The health and medical information released by this form may be used by the recipient for billing or claims review, health advocacy, or other purposes.

VI. Expiration

This authorization will remain in effect until (date or event): _____.
If left blank, this authorization will remain until revoked.

VII. Patient Rights and Acknowledgment

-I understand that I may revoke this authorization at any time by submitting a written request to the releasing entity, except to the extent that action has already been taken in reliance on this authorization.
- I understand that once information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy rules.
- I have read and fully understand the information on this form.

Signature

Patient or Legal Representative: _____
Print Name: Linda E Wilson
Date: _____