AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name:_____ **ID/SS Number:**_____

Patient Address: _____**Date of Birth:**_____

Persons/organizations providing the information: _____
(Hospital, Doctor, medical provider, etc.)

Persons/organizations you wish to receive the information:

Name: _____

Phone: _____ **Email:** _____

Address:_____

Specific description of information to release, covering health care from _____ **to** _____**:**
Check one below: (start date) (end date)

☐ Complete health records and bills (prescription bills, history and physical, discharge summary, operative reports, consultation reports, radiology and imaging reports), excluding all images (x-rays, photographs, etc.)

☐ Other (please specify) _____

The patient must read and initial the following statements:

1. I understand that this authorization will expire one year from the date of signing. **Initials:**_____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and that, if I do revoke this authorization, this will not have any effect on any action the providing organization takes before receiving the revocation. **Initials:**_____

3. I understand that I have the right to refuse to sign this Authorization. **Initials:**_____

4. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law. **Initials:** _____

Please check if you wish to authorize the release of sensitive medical information: ☐ Mental Health/Psychiatric Treatment ☐ Genetic Testing Information ☐ Alcohol or Substance Abuse Treatment ☐ STD/HIV/AIDS Treatment(s) or Test(s)

Format Requested / Delivery Method: ☐ Mail paper records to address listed above ☐ Review or pick up paper records in Health Information Management (HIM) Department ☐ Verbal release to person identified above ☐ Receive electronically via email (Check all that apply).

I have read and understand the information in this Authorization.

X_____ **Date:**_____
Signature of patient

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****