HEALTH INFORMATION RELEASE FORM

Authorization for the Use or Disclosure of Protected Health Information
(Required by HIPAA, the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

I authorize _____, to disclose the protected health information

described below to _____ (entity seeking the information).

EFFECTIVE PERIOD

This authorization for release of information covers my period of healthcare from:

☐ _____ to _____ OR ☐ all past, present, and future periods.

EXTENT OF AUTHORIZATION

☐ I authorize the release of my complete medical and dental health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse, laboratory tests, radiographs, medications, diagnostic tests, or treatments).

OR

☐ I authorize the release of my complete health record with the exception of the following information:

This information may be used by the entity I authorize to receive this information for medical or dental treatment, consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

SIGNATURE

I understand that I have the right to revoke this authorization, in writing, at any time. I also acknowledge that a revocation is not effective to the extent that any entity has already acted on my prior authorization, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information released or disclosed to the recipient pursuant to this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or representative: _____Date:_____

Printed name listed above: _____ Relationship to patient:_____