**HIPAA RELEASE AND AUTHORIZATION**

Patient’s Name: [PATIENT'S NAME] Date of Birth: [DATE OF BIRTH]

Address: [ADDRESS] Social Security Number: [SSN]

Medical Records. I hereby authorize [RELEASOR'S NAME] (“Releasor”) to use or disclose the following: (check one)

[ ]  - **ALL Medical Records**. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

[ ]  - Be Included.

[ ]  - NOT Be Included.

[ ]  - **Specific Medical Records**: [DESCRIBE MEDICAL RECORDS (IF APPLICABLE)]

Recipient. My medical records shall be disclosed to the following individual or entity:

Name: [RECIPIENT'S NAME] Contact: [CONTACT'S NAME (IF APPLICABLE)]

Address: [ADDRESS] Phone: [PHONE NUMBER]

E-Mail: [E-MAIL ADDRESS] Fax: [FAX NUMBER]

Purpose of Release: [DESCRIBE PURPOSE OF RELEASE]

Expiration. This authorization expires on: [EXPIRATION DATE OR EVENT]

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/)\_\_\_\_\_\_\_\_\_\_\_ [DATE]

**Patient or Personal Representative Signature** Date

[PATIENT OR PERSONAL REPRESENTATIVE'S NAME]

Printed Name

[PERSONAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT]

Personal Representative Relationship to Patient