HIPAA Authorization to Release Health Information (US)

Authorization under 45 CFR 164.508.

Patient

PATIENT NAME

DATE OF BIRTH

PHONE

EMAIL

Disclosure

PROVIDER / PLAN RELEASING THE INFORMATION

PERSON OR ORGANISATION RECEIVING IT

RECIPIENT ADDRESS OR FAX

SPECIFIC INFORMATION TO DISCLOSE

- [ ] Include psychotherapy notes (requires a separate authorization; tick only if this form is for that purpose)
- [ ] Include substance-use disorder, HIV/AIDS or genetic testing information

PURPOSE

EXPIRES ON (DATE OR EVENT)

Statements

- You may revoke this authorization in writing at any time, except where action has already been taken in reliance on it.
- Treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected by federal privacy rules.
- You are entitled to a copy of this signed authorization.

IF SIGNED BY A REPRESENTATIVE: NAME AND AUTHORITY

Patient or representative

SIGNATURE

PRINTED NAME

DATE