HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Sectio	n I			
l,			, give my permission for	
 Sectio	n II of this	docum	to share the information listed in nent with the person(s) or organization(s) I have specified in Section IV	
	documen		the person(s) or organization(s) mave specified in Section iv	
Sectio	n II – Heal	th Info	rmation	
I woul	d like to gi	ive the	above healthcare organization permission to:	
Tick as	s appropri	ate		
		Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.		
Or				
		Disclos	e my complete health record except for the following information	
			Mental health records	
			Communicable diseases including, but not limited to, HIV and AIDS	
			Alcohol/drug abuse treatment records	
			Genetic information	
			Other (Specify)	
Form (of Disclosu	ıre:		
	Electronic copy or access via a web-based portal			
	Hard co	ру		
Sectio	n III – Rea	son for	Disclosure	
			ns why information is being shared. If you are initiating the request for do not wish to list the reasons for sharing, write 'at my request'.	
				

Section IV – Who Can Receive My Health In	formation
I give authorization for the health information shared with the following individual(s) or organizations.	on detailed in section II of this document to be ganization(s)
Name:	
Organization:	
Address:	
I understand that the person(s)/organization state/federal rules governing privacy and sec share the information that is provided to the	curity of data and may be permitted to further
Section V – Duration of Authorization	
This authorization to share my health inform	ation is valid:
Tick as appropriate	
a) From	to
Or	
b) All past, present, and fut	ture periods
Or	
c) The date of the signature	e in section VI until the following event:
I understand that I am permitted to revoke t time and can do so by submitting a request i	his authorization to share my health data at any n writing to:
Name:	
Organization:	
Address:	

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

• I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI - Signature

Signature: ______ Date: ______ Print your name: ______ If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information: Name of person completing this form: ______ Signature of person completing this form: ______ Describe below how this person has legal authority to sign this form: