



## Medical Records Release Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

### **My Authorization**

**I authorize \_\_\_\_\_ to use or disclose the following health information:**

- All of my health information

- My health information relating to the following treatment or condition:

\_\_\_\_\_

- My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

- Other: \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name or Organization \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**The purpose of this authorization is (check all that apply):**

- At my request

- Other: \_\_\_\_\_

**This authorization ends:**

- On (date) \_\_\_\_\_

- When the following event occurs: \_\_\_\_\_

**My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

A copy of this authorization is as valid as the original and available upon request.

**Signature of Patient:** \_\_\_\_\_

Date: \_\_\_\_\_

**If the patient is a minor or unable to sign, please complete the following:**

- Patient is a minor: \_\_\_\_\_ years of age

- Patient is unable to sign because: \_\_\_\_\_

**Signature of Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Print Name of Authorized Representative: \_\_\_\_\_

Authority of representative to sign on behalf of the patient:

- Parent    - Legal Guardian    - Court Order    - Other: \_\_\_\_\_