Authorization for Release of Health Information

Complete this form to request disclosure of records. This authorization may be revoked in writing except to the extent already relied upon.

PATIENT

Patient name

Date of birth

Address

Telephone

Email

RELEASE DIRECTION

Release records FROM (person/entity and address)

Release records TO (person/entity and address)

Recipient telephone

Recipient fax / secure email

INFORMATION AUTHORIZED

- [ ] Consultation notes
- [ ] Operative reports
- [ ] Laboratory/pathology
- [ ] Photographs
- [ ] Medication list
- [ ] Billing records
- [ ] Complete record
- [ ] Other - describe below

Other / date range / purpose of disclosure

SENSITIVE INFORMATION

Initial each category only if specifically authorized and legally applicable.

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HIV-related information initials

Mental-health information initials

Substance-use disorder records initials

Genetic information initials

EXPIRATION AND DELIVERY

Expiration date or event

Preferred delivery method

I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA, except where another law applies. Treatment, payment, enrollment, or benefits will not be conditioned on signing except as permitted by law.

SIGNATURE

Printed name

Date

Signature (sign after printing or use an approved e-signature workflow)

By signing, I confirm that I reviewed this form and that the information I provided is accurate to the best of my knowledge.