Medical Information Release Request Form

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPPA) privacy regulations. If any field is left blank the authorization will be considered defective.

Patient's Name: _____ Date of Birth: _____/_____/_____

Address: _____ _____ City: _____ State: _____ Zip: _____

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to RELEASE my Health Information:

Agency or Individual(s) Authorized to RECEIVE my Health Information:

Health information AUTHORIZED to be used AND/OR disclosed is limited to the following.

☐ **SEND ALL MY REQUESTED RECORDS LISTED BELOW DEEMED NECESSARY,**

OR SEND JUST THE RECORD TYPES CHECKED BELOW: (Check specifically the record type that applies)

☐ History/Physical ☐ Medical Notes ☐ Labs/Including HIV ☐ Pathology ☐ Maternity

☐ Imaging Studies ☐ Demographic/ Insurance ☐ Hospitals/Urgent Care ☐ Other:

The above selected Health information may be released for the following period of time.

☐ **12 Months starting on date of signature below**

☐ **Specific release dates only:** From (date): _____/_____/_____ To (date): _____/_____/_____

Health information to be released to the above named office/individuals is to be used or disclosed for the following purpose(s):

☐ May use for **ALL reasonable purposes** ☐ Treatment/Consultation ☐ Billing/Claims ☐ Other:_____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. I hereby discharge the releasing office, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility." **NOTICE TO RECEIVING OFFICE/INDIVIDUAL: This information is to be treated in accordance with HIPPA Privacy regulations.**

Patients/ Authorized Personal Representatives Signature:_____ Date:___/___/_____

Relationship to Patient/Authority to Act on Patients Behalf:_____