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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO:_____
NAME OF HEALTHCARE PROVIDER/PHYSICIAN/FACILITY/ATTORNEY/RECORDS REQUESTOR/AGENT, ETC.

_____
STREET ADDRESS

_____
CITY STATE ZIP

RE: PATIENT NAME: _____

DATE OF BIRTH_____SOC SEC NO:_____

This protected health information is disclosed for the purposes:_____

_____

I authorize and request the disclosure of all protected information for the purpose of:_____

_____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

( ) All medical records, meaning every page in my record, including but not limited to: office notes, face sheet, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical chart, reports, order sheets, progress notes, nursing notes, clinic records, treatment plans, admission records, discharge summaries, procedure reports, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

( ) All medical billing records including all statements, insurance claim forms, itemized bills, and records of billing third payers and payment or denial of benefits for the period of_____to_____.

( ) All physical, occupational and rehab records, consultations, and progress notes.

( ) All laboratory, histology, cytology, pathology, autopsy, immunohistochemistry records and specimens; radiology reports and films/CDs if kept in office, CT scan, MRI, MRA, EMG, bone scan, myleogram, nerve conduction studies.

( ) All pharmacy / prescription records as documented in clinical electronic medical records.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) and alcohol or any street drug or illegal substance abuse.

( ) I authorize the release or disclosure of this type of information.
( ) I Do Not authorize the release or disclosure of this type of information.

*This authorization is given in compliance with federal consent requirements for release of alcohol or substance abuse records of 42CFR 2.31, the restrictions of which have been specifically considered and expressly waved.*

I understand the following: (see CFR 164.508 (c) (2) (i-iii))

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released is response to this authorization maybe re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be force and in effect until two years from this date of execution or at a time that a minor becomes 18 years of age at which time this authorization expires.

_____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of the Legally Authorized Representative to Patient

_____

Witness Signature Date

The following people are permitted to get medical information:

NAME: RELATIONSHIP:

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