## **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.

Section I			
Ι,		, give my permission for	
		to share the information listed in	
	ocument.	nent with the person(s) or organization(s) I have specified in Section IV	
Section I	I – Health Info	ormation	
I would I	ike to give the	above healthcare organization permission to:	
Tick as a	opropriate		
		se my complete health record including, but not limited to, diagnoses, t results, treatment, and billing records for all conditions.	
Or			
	Disclose 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	Disclosure:		
<b>-</b>	Electronic copy	y or access via a web-based portal	
П	Hard copy		
Section I	II – Reason fo	r Disclosure	
		ns why information is being shared. If you are initiating the request for d do not wish to list the reasons for sharing, write 'at my request'.	
		<del></del>	

Section IV – Who Can Receive My Health Information
I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)
Name:
Organization:
Address:
I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.
Section V – Duration of Authorization
This authorization to share my health information is valid:
Tick as appropriate
a) From to
Or
b) All past, present, and future periods
Or
c) The date of the signature in section VI until the following event:
I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in 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: