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HIPAA Compliant Records Release Form

Patient Information:
First Name:_____ Last Name:_____
Street Address:_____ City_____
State: _____ Zip:_____ Phone Number:_____
Birthdate(mm/dd/yyyy): _____

I,_____, authorize _____to release the following medical information to: _____ for the following purpose(s):_____(or at the request of the individual).

Please initial the appropriate box:
____All of my medical records (as of the date of this release)
____All of my medical record except the following:_____
____Only the following information:_____

This authorization also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed):
____Any record of treatment for alcohol and/or other substance abuse
____Any record of mental health treatment
____Any record of testing, treatment, reporting, or research pertaining to infection with HIV, any sexually transmitted diseases, or pregnancy termination

This release is effective for 1 year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above-named party. I acknowledge receiving a completed copy of release.

A copy of this form is acceptable authorization for the release of the above information

Notices of Person Authorization Disclosure

The information released pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

Printed Name:_____

Signature:_____

Patient/Legal Representation/Officer of the Court Authorizing Disclosure
Date:_____

Relationship to Patient:_____