HIPAA Release Form

Authorizing Release of Confidential Health Information and Records

I, (print name)_____, "the Releasor," born on _____ and currently residing at _____ hereby direct all my health care and medical services providers and payers to disclose and release my protected health information described herein to "the Releasee" identified as:

_____ _____

Name of Releasee (print above) Relationship to Releasor (print above)

Releasee's Contact Information:

_____

(print residential address, phone numbers, email address)

Health Information to be disclosed upon the request of the Releasee (Check either A or B):

- □ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- □ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - □ Mental health
  - □ Communicable diseases (including HIV and AIDS)
  - □ Alcohol/drug abuse treatment
  - □ Other (please specify):

Form of Disclosure (unless another format is mutually agreed upon between my health provider and Releasee) (Check one or more):

- □ Electronic record or access to my information through an online portal
- □ Hard copy
- □ Verbal Release

This authorization shall be effective until I revoke it for (Check one):

- □ All past, present, and future periods, **OR**
- □ Date or event:_____

NOTE: This HIPAA release authorization may be revoked in writing at any time by notifying applicable health care providers, preferably in writing.

_____ _____

Signature of the Releasor Date signed

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

This form is modeled on the American Bar Association's model form prepared by the Commission on Law and Aging. Check with your health care providers to determine if this form will be effective.