

# MEDICAL REPORT RELEASE AUTHORIZATION FORM (HIPAA)

Date: [DATE]

- I. **THE PATIENT.** In accordance with HIPAA privacy standards, this form should be used when permission is required.

Patient's Name: \_\_\_\_\_  
Date of Birth: [DATE OF BIRTH]  
Social Security Number [SSN]: \_\_\_\_\_

- II. **AUTHORIZATION.** This is my authorization for [AUTHORIZED PARTY'S NAME] to use or disclose the following: (select one)

- My entire medical records.
- Only medical information related to [ENTER MEDICAL CONDITION]
- Information about my medical history from [DATE] to [DATE].
- Other: [OTHER]

Henceforth referred to as "Medical Records."

- III. **DISCLOSURE.** I authorize the Authorized Party to disclose my medical records to: (select one)

- Any party with the Authorized Party's approval.
- ONLY parties listed below:  
Name: [RECIPIENT'S NAME]  
Address: [ADDRESS]  
Phone: [PHONE] Fax: [FAX]  
E-Mail: [E-MAIL]

- IV. **PURPOSE.** Authorization is based on: (select one)

- **General Purpose.** At my request (general).
- **Receiving payment.** to permit the Authorized Party, upon receipt of payment from a third party, to communicate with me for marketing purposes.
- **The sale of medical records.** to consent to the sale of my medical records by the authorized party. I am aware that if I revoke this authorization, the Authorized Party will cease all further sales and receive payment for disclosing my medical records.
- **Other:** [OTHER]

- V. **TERMINATION.** This authorization will terminate: (select one)

- Upon receipt of the Authorization Party's written revocation.
- On the following date: [DATE]
- Other: [OTHER]

**VI. ACKNOWLEDGMENT OF RIGHTS.**

I am aware that I can revoke this permission at any time, in writing, with the exception of cases where uses or disclosures have already been made using my original permission. If this authorization is being used to obtain insurance, I may not be able to revoke it.

I am aware that once uses and disclosures based on my initial permission have been made, they cannot be undone.

I am aware that Medical Records and other information used or disclosed with my consent may be disclosed again by a recipient and no longer be covered by the HIPAA Privacy Standards.

I am aware that signing this authorization may not be a requirement for receiving treatment from any party (unless the treatment is being requested solely to participate in a research study or to create medical records for a third party), and that I may choose not to sign it.

I will receive a copy of this authorization after I have signed it. This authorization is valid in its original form as well as a copy.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_

**(USE THE SIGNATURE AREA BELOW IF THE PATIENT IS UNABLE TO SIGN)**

The patient is unable to sign due to: (select one)

- **Being a Minor.** In accordance with state law, the patient is [number] years old and considered a minor.
- **Being Incapacitated.** There is an incapacitating condition affecting the patient: [DESCRIBE CONDITION]
- **Other:** [OTHER]

**Signature of Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient:  Parent  Spouse  Guardian  Other: [OTHER]

## CONSENT ADDITIONAL TO CERTAIN CONDITIONS

- I. **SENSITIVE INFORMATION.** This medical file might include details about sexual or physical abuse, alcoholism, drug abuse, STDs, abortion, or mental health treatment. This information cannot be disclosed without separate authorization.

(select one)

- I **consent** to the release of the above information.
- I **do not consent** to the release of the above information.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name on Print: \_\_\_\_\_

- II. **HIV/AIDS.** Information about HIV testing, AIDS diagnosis, and/or treatment may be included in this medical file. The release of this information requires separate consent.

(check one)

- I **consent** to the release of the above information.
- I **do NOT consent** to the release of the above information.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name on Print: \_\_\_\_\_