

Medicare Consent to Release Medical Records Form

Date: [DATE]

1. THE PATIENT. This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: [PATIENT'S NAME]

Date of Birth: [DATE OF BIRTH]

Social Security Number: [SSN]

2. AUTHORIZATION. I hereby authorize [AUTHORIZED PARTY'S NAME] ("Authorized Party") to utilize or disclose the following: (please select one)

- All of my medical-related information.
- Only my medical information pertaining to: [ENTER MEDICAL CONDITION]
- My medical-related information from [DATE] to [DATE].
- Other: [OTHER]

Hereafter referred to as the "**Medical Records.**"

3. DISCLOSURE. The Authorized Party is hereby granted permission to disclose Medical Records to: (please select one)

- Any party approved by the Authorized Party.

- Solely to the following party:

Name: [RECIPIENT'S NAME]

Address: [ADDRESS]

Phone: [PHONE] Fax: [FAX]

Email: [E-MAIL]

4. PURPOSE. The purpose of this authorization is: (please select one)

- General Purpose. At my request (general).

- For Payment Processing. To permit the Authorized Party to communicate with me for marketing purposes upon receipt of payment from a third party.

- For Sale of Medical Records. To allow the Authorized Party to sell my Medical Records. I acknowledge that the Authorized Party will receive compensation for the disclosure of my Medical Records and will discontinue any future sales upon revocation of this authorization.

- Other: [OTHER]

5. TERMINATION. This authorization shall cease: (please select one)

- Upon written revocation submitted to the Authorization Party.

- On the following specified date: [DATE]

- Other: [OTHER]

6. ACKNOWLEDGMENT OF RIGHTS.

I acknowledge that I reserve the right to revoke this authorization in writing at any time, except where uses or disclosures have already been actioned based on my initial consent. Revocation may not be feasible if this authorization was utilized to acquire insurance.

I understand that uses and disclosures made in reliance on my original consent cannot be reversed.

I acknowledge that Medical Records and information disclosed with my consent may be further disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be dependent on my execution of this authorization (unless treatment is specifically sought to generate Medical Records for a third party or to participate in a **research** study), and that I reserve the right to decline to sign this authorization.

I will receive a duplicate of this authorization subsequent to its execution. A duplicate of this authorization holds the same validity as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

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

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

- Being a Minor. Patient is [#] years old and classified as a minor under state law.

- Being Incapacitated. Patient is incapacitated due to: [DESCRIBE CONDITION]

- Other: [OTHER]

Signature of Representative: _____ **Date:** _____

Print Name: _____

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

ADDITIONAL CONSENT FOR SPECIFIC CONDITIONS

SENSITIVE INFORMATION. This medical record may contain details regarding physical or sexual abuse, alcoholism, substance abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate

consent must be granted prior to the release of this information.

(please select one)

- I consent to the release of the above information.

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

Signature of Patient: _____ **Date:** _____

Print Name: _____

HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be granted for the release of this information.

(please select one)

- I consent to the release of the above information.

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

Signature of Patient: _____ **Date:** _____

Print Name: _____