Medical Information Release Form

This form is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I. AUTHORIZATION.** I authorize the following disclosing parties, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to use or disclose the following health information:

* All my health record
* All health information relating to this specific condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* All health information within this particular timeframe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The parties mentioned above are allowed to disclose the details to the following recipient:

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this authorization is:

* Done at my request
* To authorize the disclosing party for marketing purposes when they receive payment from a third party
* To authorize the disclosing party to sell my health information. Both parties understand that the seller cannot use the disclosed information once I revoke this authorization.
* Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization ends on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or when this event occurs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whichever happens first.

**II. RIGHTS.** I understand that I have the right to revoke this authorization at any time through writing, except when disclosures are already done based on my initial decision. In order to properly revoke my authorization, I must do it in writing and send it to the appropriate using or disclosing party.

All uses and disclosures done following my original decision cannot be taken back.

I understand that there is a possibility that my medical records can be reshared or re-disclosed by the recipient, which is no longer protected by the HIPAA privacy standards.

I understand that I will receive a copy of this document after I signed it. Any copy of this document is as valid as the original.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a minor or unable to sign the document

* Patient is a minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ years old
* Patient is unable to sign because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority of the Representative to sign in behalf of the Patient:

* Parent
* Legal Guardian
* Court Order

**III. ADDITIONAL CONSENT FOR CERTAIN CONDITIONS.** This medical record may contain certain sensitive information regarding physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate and additional consent is necessary

* I consent to have the above mentioned information
* I do NOT consent to have the above mentioned information

Authorized Representative’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IV. ADDITIONAL CONSENT FOR HIV/AIDS.** This medical record may contain information regarding HIV testing and/or AIDS diagnosis or treatment. Separate and additional consent is necessary

* I consent to have the above mentioned information
* I do NOT consent to have the above mentioned information

Authorized Representative’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_