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: ___________________