HIPAA Release

Phone: 1.844.800.5777 Fax: 1.844.800.5770

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ ID Number: _____

Persons/Organizations providing the information: _____ Persons/Organizations receiving the information: _____

_____ _____

_____ _____

_____ _____

_____ _____

Specific description of information (including date(s)): _____

_____

_____

_____

Section B: Must be completed only if a Health Plan or a Health Care Provider has requested the authorization.

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? _____
      _____
      _____
   b. Will the Health Plan or Health Care Provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?
      - Yes: _____
      - No: _____
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
      - Initials_____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
      - Initials_____

Section C: Must be completed for all authorizations.

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____(DD/MM/YR) Initials:_____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials_____

Signature of patient or patient's representative: _____ Date: _____

(The Form MUST be completed before signing)

Print Name of patient's representative: _____

Relationship to Patient: _____