



HIPAA Medical Release Form

Patient Information:

- Name: _____
- Date of Birth: _____ SSN: _____
- Phone Number: _____

Authorization for Use/Disclosure:

- I authorize: _____
- To disclose my protected health information to:
 - Name: _____
 - Address: _____
 - Phone Number: _____

Information to be Disclosed:

- Complete Medical Record
- Treatment Information
- Payment Information
- Other: _____

Purpose of Disclosure:

- Continuation of Care
- Legal
- Insurance
- Other: _____

Signature of Patient: _____

Date: _____