HIPAA Compliance Release Form

Date of Authorization: _____

Individual Information:

- **Full Name: _____**
- **Contact Number: _____**
- **Address: _____**

Recipient Information:

- **Name of Entity/Person: _____**
- **Address: _____**
- **Contact Number: _____**

Authorization Details:
I authorize [Name of Entity/Person] to use or disclose my protected health information for the following purposes:

- **☐ Medical Treatment**
- **☐ Legal Compliance**
- **☐ Insurance Claims**
- **☐ Other (Specify): _____**

Details of Information to Be Released:

- **☐ Complete Medical History**
- **☐ Lab Reports**
- **☐ X-rays or Imaging Results**
- **☐ Other: _____**

Acknowledgment of Rights:
I understand that:

- **I have the right to revoke this authorization in writing at any time.**
- **Disclosed information may no longer be protected under HIPAA.**
- **This authorization is voluntary, and I may refuse to sign.**

Expiration Date:

This authorization will expire on [Date] or upon the occurrence of [Event].

Signature of Individual: _____

Date: _____

Witness (Optional):

- **Name: _____**
- **Signature: _____**