HIPAA Release Form for Medical Records

Date of Authorization: ________________________________

Patient Information:

- **Full Name: ____**
- **Date of Birth: _______________________________________**
- **Contact Number: _____________________________________**
- **Email Address: ______________________________________**

Recipient Information:

- **Name of Recipient: ___________________________________**
- **Relationship to Patient: _____________________________**
- **Address: ____**
- **Contact Number: _____________________________________**

Authorization Scope:
I authorize the release of the following medical records to the recipient named above:

- ☐ **Entire Medical History**
- ☐ **Records for a Specific Date(s): _____________________**
- ☐ **Specific Information (e.g., lab results): ______________**
- ☐ **Other (Specify): ___________________________________**

Purpose of Release:

- ☐ **Personal Use**
- ☐ **Insurance Claims**
- ☐ **Legal Use**
- ☐ **Other: ____**

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Expiration of Authorization:

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

Acknowledgment of Understanding:

I understand the risks of disclosing health information and my rights to revoke this authorization.

Signature of Patient: ____________________________________

Date: ____

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