Medical Records Request Form HIPAA

Patient Authorization for Release of Protected Health Information

Patient Name: ____

Date of Birth: ____

Address: ____

Phone Number: ____

Records to Be Disclosed

☐ Complete Medical History

☐ Immunization Records

☐ Mental Health Records

☐ Drug and Alcohol Treatment Records

☐ Other (Specify): ____

Purpose of Disclosure

☐ Continuation of Care

☐ Personal Use

☐ Legal

☐ Insurance Claims

☐ Other (Specify): ____

Recipient Information

Recipient Name: ____

Relationship to Patient: ___________________________________

Delivery Method:

☐ Email: ____

☐ Physical Address: ___________________________________

Authorization Validity

☐ Valid until (Specify Date): _______________________

☐ Valid until revoked in writing.

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Acknowledgment and Signature

By signing below, I acknowledge this request complies with HIPAA regulations and authorize the specified disclosures.

Signature: ______________________________ Date: _________________________

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