**HIPAA Release Form**

#### **Patient Details**

**Full Name: \_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_
SSN (Last 4 Digits): \_\_\_\_\_\_\_\_\_\_**

#### **Authorized Party**

**I authorize the disclosure of my protected health information to:
Name: \_\_\_\_\_\_\_\_\_\_
Relation: \_\_\_\_\_\_\_\_\_\_
Contact Information: \_\_\_\_\_\_\_\_\_\_**

#### **Information to Be Released**

**☐ Full Medical Record
☐ Billing Records
☐ Prescription History
☐ Mental Health Records
☐ Other (Specify): \_\_\_\_\_\_\_\_\_\_**

#### **Duration of Authorization**

**This authorization will remain valid until:
☐ A specified date: \_\_\_\_\_\_\_\_\_\_
☐ The completion of medical care
☐ Until revoked in writing**

#### **Patient Consent**

**By signing below, I acknowledge that I have read and understood this form.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_**

**Witness Name: \_\_\_\_\_\_\_\_\_\_
Signature: \_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_**