**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: \_\_\_\_\_\_\_\_\_\_**