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: _____