HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This HIPAA Authorization allows the individual named below to authorize the disclosure of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Individual Information

Full Legal Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Authorized Persons to Receive Medical Information

I authorize the following individual(s) to receive my protected health information:

Name: _____ Relationship: _____

Phone / Email: _____

Name: _____ Relationship: _____

Phone / Email: _____

Information Authorized for Disclosure

This authorization applies to all medical information including, but not limited to:

- Medical records
- Diagnosis and treatment information
- Test results
- Mental health information (unless prohibited by law)

Expiration of Authorization

This authorization shall remain in effect until:

_____

or until revoked in writing by the individual.

Individual Authorization

I understand that I may revoke this authorization at any time by providing written notice. I acknowledge that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA.

Signature of Individual: _____ Date: _____

Notary Acknowledgment

State of _____
County of _____

On this ____ day of _____, 20____, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to this instrument and acknowledged that they executed the same.

Notary Signature: _____

Notary Printed Name: _____

Commission Number: _____

Commission Expiration Date: _____

[NOTARY STAMP / SEAL]