

Date of request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration of authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

|  |  |
| --- | --- |
| Patient Name (Print) |  |
| Patient Date of Birth |  |

Name and address of Doctor / Facility where patient’s medical records are located:

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |

SEND THE FOLLOWING RECORDS/REPORTS

|  |  |  |
| --- | --- | --- |
| □ | All Medical Records (See below for restrictions) for following dates: |  |
| □ | All Radiological Reports dated: |  |
| □ | All Lab Studies dated: |  |

SEND SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Telephone: |  |

I, (Patient Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby request and authorize medical records, radiological reports, and tests results to be photocopied, released, and mailed to the indicated address above for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and my protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days, unless my records are off-site which allows for an additional 30 days. This authorization may be revoked by me, at any time, by notifying the doctor’s office (privacy officer) of this revocation in writing. I have been advised that if I chose to not authorize that I will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payments.

□ I HAVE NO PROTECTED HEALTH INFORMATION FOR THE SPECIFIED TIME FRAME release all of my medical records that have been indicated above.

□ I HAVE PROTECTED HEALTH INFORMATION WITHIN THE AUTHORIZED TIME FRAME release all of the above medical records for the specified time frame except for the following \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_