HIPAA Release Form

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_____

Patient Information:

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

City: _____ **State:** _____ **ZIP:** _____

Patient's Phone Number: _____

Patient's Email Address: _____

I, _____ hereby authorize the release of my protected health information (PHI) as described below:

1. **Purpose of Release:**

   _____

_____

_____

2. **Information to be Released:**

   _____

_____

_____

3. Recipient of Information:

_____

_____

_____

4. **Duration of Authorization**:

   _____

_____

_____

5. **Revoke Authorization:** I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must provide a written request to the releasing party.
6. **Potential Risks:** I acknowledge that the released information may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.
7. **Rights:** I understand that I have the right to refuse the release of my protected health information. I also understand that the refusal to sign this authorization will not affect my ability to obtain treatment, payment, or eligibility for benefits.
8. **Signature:** By signing below, I acknowledge that I have read and understood the contents of this authorization form. I authorize the release of my protected health information as described above.

Patient's Signature: _____

Date: _____

Healthcare provider's Signature: _____

Date: _____

Witness (if applicable):

Witness's Name: _____

Witness's Signature: _____

Date: _____