Authorization for Release of Personal Health & Medical Records

(Medical records release form in accordance with HIPAA compliance laws)

To: (provider or facility) _____

Patient's Name:_____ **Date of Birth:** _____

I authorize the release of my personal health and medical records including, but not limited to, examination records, diagnosis, test records, treatment records and provider notes.

This information may be released to:

Spouse / Partner: (name—please print) _____

Child(ren): _____

_____

_____

Advocate: _____

Other: _____

Records will accepted either in print or electronic format.
This authorization shall remain in effect until terminated in writing.
(Please ask for identification when turning over records.)

Patient Signature: _____ Date: _____

Receiver's Signature: _____ Date: _____

This request is being made in accordance with HIPAA laws and regulations as determined by the US Department of Health & Human Services.
For more information, please see:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/consumer_ffg.pdf