



# HIPAA AUTHORIZATION FORM

## FOR RELEASE OF PROTECTED HEALTH INFORMATION

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone Number:** \_\_\_\_\_

**Date(s) of Service for requested information:** \_\_\_\_\_

**I hereby authorize (name and address of hospital/doctor's office that created the medical records): Place name of facility/Doctor in this section**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**To release my medical records to (complete name, address and contact information):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please release the following information in my medical record (check all that apply):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> History & Physical     | <input type="checkbox"/> Emergency Room Record   | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Laboratory Report(s)    | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> X-Ray/Imaging Report(s) | _____  |
| <input type="checkbox"/> Operative Report(s)    | <input type="checkbox"/> Abstract or Summary     | _____  |

**Please release the following information in my medical record (check all that apply):**

- I  do  do not want HIV/AIDS information released under this authorization.
- I  do  do not want mental health information released under this authorization.
- I  do  do not want drug/alcohol abuse or treatment information released under this authorization.
- I  do  do not want genetic testing information released under this authorization.
- I  do  do not want sexually transmitted disease information released under this authorization.

**The purpose for release of the above information is for:**

- Continuation of Care  Insurance  Legal  At my request (patient only)  Other: \_\_\_\_\_

This authorization will expire within one (1) year. I understand that this authorization is voluntary and may be revoked by me at any time in writing by sending the written revocation to the facility in which I am requesting records, except to the extent that action has already been taken in reliance with this authorization. I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization of this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

\_\_\_\_\_  
**Signature of Patient or Patient's representative**

(Personal & Legal Representative must include proof of status)

- Parent  
 Personal Representative  
 Legal Representative

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

**RETURN COMPLETED FORM TO: Iron Mountain**

**FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL BE RETURNED**