HIPAA AUTHORIZATION FOR RELEASE of HEALTHCARE INFORMATION
Authorization to Disclose Protected Health Information

Patient Information:
Name: _____
Date of Birth: _____

Information will be sent to:	Information will be sent from:
TO: _____	FROM:_____
Address: _____	Address: _____
_____	_____
Phone/FAX: _____	Phone/FAX: _____

☐ ALL RECORDS

OR SPECIFY ONLY THE FOLLOWING RECORDS TO BE SENT:

☐ Discharge Summary	☐ Psychiatric Assessment	☐ Immunization Record
☐ History & Physical Exam	☐ Initial Intake	☐ X-Ray Reports
☐ Progress Notes	☐ Psychosocial History	☐ Laboratory Reports
☐ Consultation Reports	☐ Psychological Reports	☐ Other: (please Specify)
☐ Operative Reports	☐ Treatment Plan	

I understand that specific information to be released may include, but is not limited to, my protected health information, including mental health records (excluding psychotherapy notes); drug, alcohol, or substance abuse records; genetic information (including genetic test results); and HIV/AIDS test results/treatment.

This Authorization is effective immediately and SHALL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.

This Authorization may be revoked at any time by giving written notice stating my intent to revoke to the covered entity or health care provider. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other method evidencing receipt by the Authorized Recipients. I understand that prior actions taken in reliance on this Authorization by the Authorized Recipients, who had permission to access my health information, will not be affected. There are no exceptions to my right to revoke this Authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ (Signature of Patient)	_____ (Signature of Patient's Representative) (Date)
_____ (Date)	_____ (Relationship to Patient)