MEDICAL RECORDS RELEASE / AUTHORIZATION

HIPAA Authorization for Use or Disclosure of Protected Health Information
PURSUANT TO 45 CFR § 164.508

This form authorizes the release of your protected health information (PHI). Complete all sections, sign at the bottom, and deliver to the provider holding your records. You have the right to refuse to sign, and you may revoke this authorization at any time in writing.

SECTION 1 Patient Information (the person whose records are being released)

Full legal name _____ Date of birth _____

Street address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Last 4 of SSN (optional) _____ Medical record # (if known) _____

SECTION 2 Provider Releasing the Records (the source)

Provider / facility name _____

Address _____

Phone _____ Fax _____

SECTION 3 Recipient (who should receive the records)

This may be yourself, another provider, an attorney, an insurance company, or any other party.

Recipient name _____

Address _____

Phone _____ Email / fax _____

RELEASE FORM (continued)

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SECTION 4 Records to Release

Check ALL that apply:

- ☐ ALL medical records (complete chart)
- ☐ Laboratory and pathology results
- ☐ Imaging study files (DICOM images, not just reports)
- ☐ Immunization records
- ☐ Discharge summaries
- ☐ Billing and claims records
- ☐ Clinical notes / progress notes / consultation notes
- ☐ Imaging reports (X-ray, MRI, CT, ultrasound, etc.)
- ☐ Medication and prescription history
- ☐ Operative and procedure reports
- ☐ Emergency department records
- ☐ All electronic health information (EHI)

Date range:

From _____ To _____

☐ OR check here to release ALL records regardless of date

SECTION 5 Sensitive Records (separate authorization required by HIPAA)

Check each category you specifically authorize. If unchecked, these records will NOT be released.

- ☐ Mental health / psychiatric records (other than psychotherapy notes)
- ☐ Drug, alcohol, or substance use disorder treatment records (42 CFR Part 2)
- ☐ HIV/AIDS testing, diagnosis, or treatment records
- ☐ Genetic testing or hereditary disease information
- ☐ Reproductive health, abortion, or sexually transmitted disease records

SECTION 6 Purpose of Release

- ☐ Continuing my medical care
- ☐ Personal use / my own records
- ☐ Legal matter
- ☐ Insurance claim / disability claim
- ☐ Other (specify): _____

SECTION 7 Delivery Method (how the records should be sent)

- ☐ Electronic, preferred (secure portal or encrypted email)
- ☐ PDF by email to the recipient address above
- ☐ Paper copy by U.S. mail
- ☐ I will pick up in person
- ☐ Fax to the recipient fax number above

SECTION 8 Expiration of This Authorization

HIPAA requires an expiration. If you don't specify, this authorization expires one year from signature.

Expires on (date) _____ OR upon event _____

RELEASE FORM (continued)

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SECTION 9 Your Rights

I understand: (1) I have the right to refuse to sign this authorization. (2) I may revoke this authorization at any time, in writing, by sending notice to the provider releasing the records, except to the extent the provider has already acted in reliance on it. (3) Once the records are released, the recipient may re-disclose them and they may no longer be protected by federal privacy law. (4) Treatment, payment, enrollment, and eligibility for benefits cannot be conditioned on signing this authorization (except in limited cases involving research or eligibility determinations).

Patient signature _____ **Date** _____

If you are signing as a personal representative (parent, legal guardian, executor, agent under healthcare power of attorney):

Rep name _____ Relationship _____

Rep signature _____ **Date** _____