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| --- | --- |
| Patient Name: | SSN: |
| AKA Name(s):  | Date of Birth:  |

Person/Organization to receive information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/ Organization to release information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of information to be released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the use and disclosure of health care and/or other information as described above:

* I understand that the Notice of Use of Private Health Care Information describes my rights and how my information will be used
* My authorization is voluntary, but a refusal to sign this authorization may affect my enrollment or eligibility, for benefits
* Because my records may contain sensitive information, the individuals and organizations named are limited to requesting and releasing the minimum amount of information necessary.
* My information to be released to others who must continue to keep this information confidential to the extend required by federal and state law.
* I may specify the length of time for my authorization to be in effect
* My authorization may be revoked at any time in writing on a form that states it is a revocation of my authorization, but the revocation will have no effect on actions that happened before it was received.
* I may request a copy of this signed authorization

This authorization expires on the following date or event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature of named individual or legal representative Date

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Printed name of legal representative or witness Description of representative’s authority

PATIENT RELEASE OF INFORMATION AUTHORIZATION REQUIRED FOR ALL PATIENTS

HIPPA COMPLAINT