All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name	Date of Birth	Medical Record Number
Address	City, State, Zip	Telephone Number

(FROM) Releasing Facility:
Facility Name: ______________________________
Attention: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ____________ ____ Fax: ______________

(TO) Receiving Facility
Facility Name: ______________________________
Attention: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________ Fax: ______________

Health Information that may be used / disclosed is limited to the following:

- ☐ Progress Notes
- ☐ Emergency Room Record
- Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Lab
- ☐ Pathology Report
- Operative Note(s)
- ☐ Imaging/X-ray
- ☐ X-ray Reports
- Entire Record
- ☐ Other (specify)

Health information that may be used / disclosed is limited to the following periods of healthcare:

From (date): To (date): Account Number:
From (date): To (date): Account Number:

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information herein, to include alcohol, drug abuse, communicable disease including HIV status, and /or psychiatric diagnoses compiled during my visits, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

☐ Yes ☐ No

If applicable, I agree to the release of my medical or billing records containing the sensitive information listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right ot revoke this authorization at any time, in writings, as stated in the Notice of Privacy Practices, except where the facility has already made disclosure sin reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patients or Authorized Personal Representatives Signature	Date	Time
Relationship to Patient/Authority to Act on Patient's Behalf	Interpreter, If Utilized	
Witness Signature	Expiration Date or Event	

- ☐ Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records
- ☐ Electronic Copy Requested