HIPAA Authorization for Health Information Release

Patient Information

Patient Name:

[ ]

Date of Birth:

[ ]

Address:

[ ]

Information to be Released

Describe the information to be released:

[ ]

Release Information To

Recipient Name/Organization:

[ ]

Recipient Address:

[ ]

Purpose of Release

Purpose:

[ ]

Authorization Duration

This authorization expires on (date or event):

[ ]

Signature

Patient Signature:

[ ]

Date:

[ ]

Submit