

# MEDICAL RECORDS RELEASE FORM (HIPAA AUTHORIZATION)

## HIPAA Authorization for Release of Protected Health Information

This Authorization for the Release of Protected Health Information (this "Authorization") is executed as of (the "Effective Date") and is given pursuant to 45 C.F.R. §164.508 of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

### 1. Patient Information

- **Patient Name:** [PATIENT NAME]
- **Date of Birth:**
- **Medical Record Number:**
- **Address:** [PATIENT ADDRESS]

### 2. Person Signing This Authorization

The Patient identified above is signing this Authorization personally.

### 3. Provider Releasing Records

- **Name:** [PROVIDER NAME]
- **Address:** [PROVIDER ADDRESS]

The Patient hereby authorizes the Provider identified above (the "Provider") to disclose the Protected Health Information described in Section 5 to the Recipient identified in Section 4.

### 4. Recipient of Records

- **Name:** [RECIPIENT NAME]
- **Recipient Type:** Provider
- **Address:** [RECIPIENT ADDRESS]

### 5. Description of Information to Be Released

**Scope.** All medical records created or maintained by the Provider regarding the Patient for encounters occurring from \*\*\*\* through \*\*\*\*, inclusive.

**Categories included.** The Authorization covers the following record categories:

- Physician and progress notes

- Laboratory results
- Imaging studies (X-ray, MRI, CT, ultrasound)
- Discharge summaries

**Excluded records.** This Authorization does **not** cover (a) private psychotherapy notes as defined in 45 C.F.R. §164.501, or (b) information compiled in reasonable anticipation of, or for use in, civil, criminal, or administrative proceedings, in each case as excluded from the right of access under 45 C.F.R. §164.524(a)(1).

## 6. Purpose of Disclosure

**Purpose:** Continuing or follow-up medical care.

## 7. Delivery Method

The Patient requests that the records be delivered by: **Secure Email**.

Under 45 C.F.R. §164.524(c)(2), the Provider shall provide the records in the electronic form and format requested by the Patient if the records are readily producible in that form and format. If not, the Provider shall provide the records in a readable electronic form and format as agreed by the Patient and the Provider.

## 8. Expiration

This Authorization expires **one (1) year** after the Effective Date, unless sooner revoked in writing.

After expiration, the Provider shall cease processing any request for records under this Authorization; a new authorization will be required.

## 9. Right to Revoke

The Patient has the right to revoke this Authorization at any time by delivering a **written** notice of revocation to the Provider at the address set forth in Section 3. The revocation will take effect upon the Provider's receipt of the written notice, except to the extent the Provider has already acted in reliance on this Authorization before receiving the revocation. 45 C.F.R. §164.508(c)(2)(i).

## 10. Voluntary Signing; No Conditioning of Treatment

The Patient's signing of this Authorization is voluntary. The Provider may not condition the Patient's treatment, payment, enrollment in a health plan, or eligibility for benefits on the Patient's signing of this Authorization, except in the limited circumstances permitted by 45 C.F.R. §164.508(b)(4).

## 11. Re-Disclosure Warning

The Patient understands that Protected Health Information disclosed pursuant to this Authorization may be re-disclosed by the Recipient and, once re-disclosed, may no longer be protected by the federal privacy regulations at 45 C.F.R. Part 164 or equivalent state privacy law. 45 C.F.R. §164.508(c)(2)(iii).

## State-Specific Notices

### General Provisions

**Electronic signatures.** The Patient (or Representative) and the Provider acknowledge that electronic signatures on this Authorization are valid and binding under the federal ESIGN Act (15 U.S.C. §7001 et seq.) and applicable state UETA equivalents, provided the Provider accepts electronic signatures.

**Severability.** If any provision of this Authorization is held invalid or unenforceable, the remainder shall continue in full force and effect.

**Governing law.** This Authorization is governed by HIPAA and by the laws of the State of [STATE].

## Signatures

### Patient

\_\_\_\_\_ PRINTED NAME

\_\_\_\_\_ SIGNATURE

\_\_\_\_\_ DATE

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### Revocation of Authorization (for future use)

The Patient may revoke this Authorization at any time by delivering a signed, written notice of revocation to [PROVIDER NAME] at [PROVIDER ADDRESS]. A template revocation notice is available from the Provider or from the issuing platform.