HIPPAA Release Form

I, _____, direct my health care and medical services providers and payers to disclose and release my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

Name: _____

Relationship_____

Contact information: _____

____ Information is not to be released to anyone

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

____ An electronic record or access through an online portal

____ Hard copy

This authorization shall be effective until (Check one):

_____ All past, present, and future periods.

_____ OR Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.) _____
_____

Name of the Individual Giving this Authorization_____

Date of birth of birth_____

Signature of the Individual Giving this Authorization_____Date _____