

HIPAA Release Authorization Form Sample

The **HIPAA Release Authorization Form** sample provides a clear template for individuals to grant permission for the disclosure of their protected health information. This form ensures compliance with HIPAA regulations while safeguarding patient privacy rights. Utilizing this sample helps streamline the authorization process for healthcare providers and patients alike.

Patient Information
Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information
Name of Authorized Person/Organization:

Recipient Address:

Recipient Phone:

Authorization Details
Information to be Released (describe specifically):

Purpose of Disclosure:

Expiration Date or Event:

Signature
Signature of Patient or Legal Representative:

Date:

If Legal Representative, relationship to patient:

Notice: I understand that authorizing the disclosure of this health information is voluntary. I can revoke this authorization at any time by submitting a written request to the healthcare provider.

Submit