Authorization to Release Health Information HIPAA Form Sample

The **Authorization to Release Health Information HIPAA Form** sample facilitates the secure and legal sharing of medical records between healthcare providers and authorized entities. This form ensures compliance with HIPAA regulations, protecting patient privacy while allowing necessary access to health information. Using a standardized sample simplifies the process of obtaining patient consent for information release.

Patient Information

Name:

Date of Birth:

Address:

Release Information To

Recipient Name/Organization:

Recipient Address:

Information to be Released

Specific Information (e.g., Lab Results, Entire Record, etc.):

Purpose of Disclosure:

Authorization

I authorize the release of my health information as described above. I understand that:
- I may revoke this authorization at any time in writing.
- Information disclosed may be subject to re-disclosure and no longer protected by federal privacy laws.
- My healthcare and payment for my healthcare will not be affected by signing this form.

Signature of Patient or Legal Representative:

Date:

Submit