Medical Authorization Form Sample (HIPAA Compliant)

Ensure patient privacy and streamline consent processes with our **Medical authorization form** sample, designed to comply fully with HIPAA regulations. This template facilitates clear communication between healthcare providers and patients, safeguarding sensitive health information. Use it to obtain authorized consent effortlessly and maintain legal compliance.

Patient Information

Full Name:

Date of Birth:

Address:

Authorization Details

I hereby authorize the use and disclosure of my health information as described below:

Healthcare Provider/Facility:

Recipient (Name/Organization authorized to receive information):

Information to be disclosed:

- ☐ Medical History
- ☐ Laboratory Results
- ☐ Imaging Studies
- ☐ Billing Information
- ☐ Other:

Purpose of Disclosure:

Authorization Expiration Date or Event:

Agreement & Signature

I understand that:
- I have the right to revoke this authorization at any time, in writing.
- This authorization is voluntary and not required for treatment, payment, or enrollment.
- My information may be re-disclosed if the recipient is not a health plan or healthcare provider.
- This authorization complies with HIPAA regulations for the protection of health information.

Signature of Patient (or Personal Representative):

Date Signed:

If signed by Personal Representative, describe relationship to patient:

Submit Authorization

This sample authorization form is provided for informational purposes only and does not constitute legal advice. For specific legal guidance regarding HIPAA compliance, consult a qualified professional.