HIPAA Compliant Authorization for Information Release

This **HIPAA compliant authorization** for information release form sample ensures the secure and lawful sharing of protected health information. Designed to meet federal privacy regulations, it facilitates patient consent and safeguards sensitive data. Use this template to streamline the information release process while maintaining compliance.

Patient Information

Patient Name:

Date of Birth:

Address:

Information to be Released

Please specify the information to be released:

- ☐ All Health Information
- ☐ Medical Records
- ☐ Billing Information
- ☐ Other (please specify):

Recipient of Information

Name/Organization:

Address/Fax/Email:

Purpose of Release

- ○ Continuing Care
- ○ Insurance
- ○ Legal
- ○ Other (please specify):

Expiration & Right to Revoke

This authorization will expire on (date or event):

You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon it.

Signature

Signature of Patient or Legal Representative:

Date:

If signed by Legal Representative, state relationship:

Submit

Notice: Information released in accordance with this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA Privacy Regulations.