HIPAA Authorization for Release of Health Information

Ensure your patients' privacy with a **HIPAA compliant authorization form sample** designed to meet all regulatory requirements. This form streamlines the process of obtaining consent while safeguarding sensitive health information. Utilize it to maintain legal compliance and build trust with your patients.

Patient Name

Date of Birth

Name of Provider or Facility Authorized to Release Information

Recipient (Name/Organization to Receive Information)

Description of Information to be Disclosed

e.g., All health information, lab results, radiology reports, billing records

Purpose of Disclosure

e.g., Treatment, payment, or healthcare operations

Expiration Date or Event

e.g., 1 year from signature date or upon discharge

Patient Rights

- You have the right to revoke this authorization at any time in writing.
- Revocation will not affect disclosures made prior to receipt of the revocation.
- You are not required to sign this form for treatment, payment, or eligibility for benefits.

Signature of Patient or Legal Representative

Date

If signed by someone other than the patient, indicate relationship:

Submit Authorization

NOTICE: Protected health information (PHI) disclosed under this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.