Authorization for Release of Protected Health Information

HIPAA-Compliant Authorization per 45 CFR § 164.508

Section 1: Patient Information

Patient Name

Date of Birth

Phone

Address (Street, City, State, ZIP)

Email

Section 2: I Authorize the Following to Release My Records

Provider / Facility Name

Provider Address

Section 3: Release My Records To

Recipient Name

Recipient Address

Recipient Email

Section 4: Information to Be Released

- [ ] Complete Electronic Health Information (EHI) Export
- [ ] All associated documents and images

Additional Description

Section 5: Purpose of Disclosure

- [ ] Personal / At the request of the individual
- [ ] Other:

Section 6: Expiration & Rights

This authorization expires one year from the date of signature, or upon fulfillment of the request, whichever comes first.

I understand that I may revoke this authorization at any time by submitting a written request. I understand that information disclosed may be subject to re-disclosure. Treatment, payment, enrollment, or eligibility will not be conditioned on signing this authorization.

Section 7: Signature

Signature

Date

(45 CFR § 164.508).