HIPAA AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

1 **Patient Name:**

2 **Date of Birth:**

3 **Social Security Number:**

4 **Individual or organization authorized to make the disclosure:**

Medical Provider:

5 **Disclose the information to the following:**

Name:

Address:

City, State, Zip:

Fax Number:

6 **Information to be disclosed:**

- ☐ Progress / SOAP notes
- ☐ Radiological/Diagnostic reports (X-ray, CT, MRI, EMG, etc.)
- ☐ Other: _____

7 **Hospitals: *DO NOT* RELEASE THE FOLLOWING UNLESS CHECKED BELOW**

- ☐ ER reports
- ☐ History and physical reports
- ☐ Consultative reports
- ☐ Discharge summary
- ☐ Surgery Reports
- ☐ Laboratory results
- ☐ Daily notes
- ☐ Nurses notes
- ☐ Medication logs
- ☐ Disclosure notices
- ☐ Authorizations
- ☐ Privacy notices
- ☐ Billing statements / itemizations
- ☐ Correspondence with insurance carrier
- ☐ Other: _____

8 **Special Authorization: I specifically authorize the release of the records concerning:**

- ☐ Alcohol and/or drug use.
- ☐ HIV/AIDS/AIDS Related Complex (ARC)

9 **Dates of Service:**

Purpose: Social Security disability claim.

Re-disclosure: I understand that if the provider is covered by the HIPAA Privacy Regulation, once the provider discloses the protected health information, it may no longer be protected by the regulation.

Expiration: This release will remain in effect for one year unless revoked.

Revocation: I may revoke this authorization, in writing, except to the extent that the recipient of this authorization has already taken action in reliance on this authorization.

Conditioning: I understand that pursuant to HIPAA Privacy Regulation, a covered entity cannot condition the provision of treatment, payment of health plan benefits, or eligibility for such benefits on the signing of an Authorization. No such conditioning has occurred regarding this authorization.

Copies: A copy of this authorization may be utilized with the same effectiveness as an original.

SIGN HERE: _____ DATE HERE: _____

HIPAA AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

1 **Patient Name:**

2 **Date of Birth:**

3 **Social Security Number:**

4 **Individual or organization authorized to make the disclosure:**

Medical Provider:

5 **Disclose the information to the following:**

Name:

Address:

City, State, Zip:

Fax Number:

6 **Information to be disclosed:**

- ☐ I specifically authorized the release of information regarding psychiatric condition(s) and their treatment
- ☐ Treatment notes (including clinician, therapist, counselor, psychiatrist, psychologist notes)
- ☐ Diagnostic test reports
- ☐ Testing reports (WISC, WAIS, MMPI, etc.)
- ☐ Other: _____

7 **Hospitals: *DO NOT* RELEASE THE FOLLOWING UNLESS CHECKED BELOW**

- ☐ ER reports
- ☐ History and physical reports
- ☐ Consultative reports
- ☐ Discharge summary
- ☐ Surgery Reports
- ☐ Laboratory results
- ☐ Daily notes
- ☐ Nurses notes
- ☐ Medication logs
- ☐ Disclosure notices
- ☐ Authorizations
- ☐ Privacy notices
- ☐ Billing statements / itemizations
- ☐ Correspondence with insurance carrier
- ☐ Other: _____ _____

8 **Special Authorization: I specifically authorize the release of the records concerning:**

- ☐ Alcohol and/or drug use.
- ☐ HIV/AIDS/AIDS Related Complex (ARC)

9 **Dates of Service:**

Purpose: Social Security disability claim.

Re-disclosure: I understand that if the provider is covered by the HIPAA Privacy Regulation, once the provider discloses the protected health information, it may no longer be protected by the regulation.

Expiration: This release will remain in effect for one year unless revoked.

Revocation: I may revoke this authorization, in writing, except to the extent that the recipient of this authorization has already taken action in reliance on this authorization.

Conditioning: I understand that pursuant to HIPAA Privacy Regulation, a covered entity cannot condition the provision of treatment, payment of health plan benefits, or eligibility for such benefits on the signing of an Authorization. No such conditioning has occurred regarding this authorization.

Copies: A copy of this authorization may be utilized with the same effectiveness as an original.

SIGN HERE: _____ DATE HERE: _____