HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO:____
Name of Health Provider/Physician

____
Street Address

____
City, State and Zip Code

RE: ____
Patient Name

____
Date of Birth and Social Security Number

I authorize and request the disclosure of all protected information. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

________ All medical records including history and physical office notes.
________ Colonoscopy reports, operative notes, laboratory tests, x-rays

Exclusions:____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or distribution of this type of information.

The protected health information is disclosed for the following purposes:____________________________
____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following:
____
____
____

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photography of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two (2) years from date of execution, at which time this authorization expires.

____ ____________________________________
Signature of Patient or Legally Authorized Representative Date

____
Name and Relationship of Legally Authorized Representative to Patient

____ ____________________________________
Witness Signature Date

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