Release of Protected Health Information

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

First Name: _____ **MI:** _____ **Last Name:** _____
Phone #: (_____)_____-_____

Relationship to Patient: _____

Emergency Street Address: _____
City: _____ **State:** _____ **Zip:** _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

  ☐ Mental health records
  ☐ Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment
  ☐ Other (please specify): _____

  Form of Disclosure: An electronic record or access through an online portal Hard copy (unless another format is mutually agreed upon between my provider and designee)

  This authorization shall be effective until (Check one):
  ☐ All past, present, and future periods, OR
  ☐ Date or event: _____ unless I revoke it.

  (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of the Individual Giving this Authorization: _____

Date of Birth: _____

Signature: _____ **Date:** _____

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

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