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| Release Form for HIPAA | | | | |
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| **AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION** | | | | |
| Please complete **all parts** of this HIPAA Release Form. If any parts are left blank, this form will be invalid. Use N/A if not applicable. (Page 1 of 2) | | | | |
|  |
| **Part 1 – Patient/Plan Member Information** | | | | |  |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Reference Nº: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Part 2 - Individual/Organization Authorized by Signatory to Release PHI** | | | | |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Part 3 - Individual/Organization Authorized by Signatory to Receive PHI** | | | | |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| Relationship to Patient/Plan Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Part 4 - Authorization Expiry Event or Date** | | | | |  |
| Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing. | | | | |  |
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| Expiry Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| **Part 5 – Health Information to be Released - General** | | | | |  |
| I authorize the following Protected Health Information to be released: | | | | |  |
| q Medical Records | q Dental Records | | | q Other Non-Specific |  |
| If Other Non-Specific, provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| **Part 6 – Health Information to be Disclosed – Specific** | | | | |  |
| I authorize the following Protected Health Information to be released: | | | | |  |
| q Communicable Diseases | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Reproductive Health | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q HIV Test Results | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Mental Health Records \* | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Substance Use Disorder | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Other | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| If "Other", provide details: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
| **\* Requests for psychotherapy notes require a separate HIPAA Release Form and may not be combined with any other request.** | | | | |  |
|  |
| q Psychotherapy Notes | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Release Form for HIPAA | | | | | |
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| **AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION** | | | | | |
| Please complete **all parts** of this HIPAA Release form. If any parts  are left blank, this form will be invalid. Use N/A if not applicable. (Page 2 of 2) | | | | | |
|  |
| **Part 7 - Purpose of the Release or Use of Health Information** | | | | | |  |
| q Health Care q Research | | q Marketing | q Sale q Legal | | |  |
| q Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Note: The sale of PHI authorized by this HIPAA Release Form will result in remuneration to the party specified in Part 2. | | | | | |  |
| **Part 8 - Authorization Information** | | | | | |  |
| I understand the following: | |  |  | | |  |
| 1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Part 4. | | | | | |  |
|  |
| 2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Part 2. The revocation will prevent further disclosure of my health information from the date of receipt. | | | | | |  |
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| 3. I am signing this release form for HIPAA voluntarily and understand my entitlement to health care or health plan benefits will not be affected if I do not sign. | | | | | |  |
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| 4. If the party specified in Part 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal or state privacy regulations. | | | | | |  |
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|  |
| 5. I have a right to receive a copy of this Release Form for HIPAA. | | | | | |  |
| 6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization. | | | | | |  |
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| **Section 9 - Additional Conditions that Apply to this Release Form for HIPAA** | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| **Section 10 - Signature by or on Behalf of Patient/Plan Member** | | | | | |  |
| Name of Patient/Plan Member (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| Name of signatory if not patient/plan member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Authority to sign on behalf of patient/plan member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Name of translator (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Signature of translator (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |