

Medical Information Release Form (HIPAA Release Form)



Name: _____

Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and financial information. This information may be released to the following and the authorization will remain in effect until terminated by me in writing:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

Messages

Preferred communication (choose all that apply) my home my work my cell

Preferred Number(s): _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

Electronic Communications

I authorize the release of information regarding medical records or financial information to the email address listed: _____

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signed: _____ Date: ____/____/____