MEDICAL RECORDS RELEASE AND HIPAA AUTHORIZATION

I authorize the use and disclosure of health information as described in this Medical Records Release and HIPAA Authorization (this "Authorization"). It is written to meet the HIPAA Privacy Rule, 45 C.F.R. section 164.508.

Patient name: _____ Date of birth: _____

Address: _____ Phone: _____ Medical record or member number: _____

1. WHO MAY DISCLOSE THE INFORMATION

I authorize the following providers, health plans or other persons to disclose the records (each a "Discloser"): _____ _____

[ ] Or: every provider and health plan that has treated the patient or paid for the patient's care.

2. WHO MAY RECEIVE THE INFORMATION

Name: _____

Address: _____ Phone, fax or email: _____

3. INFORMATION TO BE DISCLOSED

(Check all that apply.) [ ] The complete medical record [ ] Office and visit notes [ ] Lab and test results [ ] Imaging reports and images [ ] Hospital records and discharge summaries [ ] Medication and allergy lists [ ] Immunization records [ ] Billing records [ ] Other: _____

Dates of service: [ ] all dates [ ] from _____ through _____. Form: [ ] paper [ ] electronic [ ] either.

4. SENSITIVE INFORMATION

Some records need specific permission. Initial each item you authorize. Anything not initialed is excluded. ____ Mental health records (not psychotherapy notes) ____ Substance use disorder records covered by 42 C.F.R. Part 2 (not counseling notes) ____ HIV/AIDS and sexually transmitted infection information ____ Genetic testing information

This Authorization does not cover psychotherapy notes. Federal law requires a separate authorization for them.

If substance use disorder records are initialed: a recipient may redisclose them, and once redisclosed they may no longer be protected by 42 C.F.R. Part 2. Federal law limits their use in proceedings against the patient.

This general template is provided for informational purposes only and does not constitute legal advice. Requirements vary by state and locality; review current law and attach any disclosures or addenda your situation requires before signing. For a guided state-specific document, visit lawvault.org.

5. PURPOSE

This disclosure is made at the request of the patient. The information will be used for: [ ] continuing care with another provider [ ] a family member or caregiver [ ] a legal matter [ ] an insurance or benefits claim [ ] an employer, school or program [ ] other: _____

6. EXPIRATION

This Authorization expires on _____, or when the following event occurs: _____, unless revoked sooner.

7. RIGHTS AND ACKNOWLEDGMENTS

Right to Revoke. I may revoke this Authorization at any time by written notice to a Discloser. The revocation does not affect any use or disclosure made in reliance on this Authorization before the Discloser received it, or an authorization obtained as a condition of obtaining insurance where the law gives the insurer the right to contest a claim or the policy.

No Condition on Treatment. Signing is voluntary. A Discloser may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign.

Redisclosure. Information disclosed under this Authorization may be redisclosed by the recipient and may then no longer be protected by federal privacy rules.

Right to a Copy. I have the right to receive a copy of this signed Authorization. A copy or scan of it is as valid as the original.

Personal representative (if signing for the patient): name _____; authority (parent of a minor, guardian, health care agent, executor or administrator, other): _____.

Note: California requires this form to be handwritten by the signer or printed in type no smaller than 14-point (Cal. Civ. Code section 56.11). Some states have extra rules for HIV, mental health and genetic information.

SIGNATURES

Patient or Personal Representative

Signature: _____ Date: _____

Printed Name: _____

DATE

Date signed: _____. HIPAA requires the date of signature.

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