~ HIPPA MEDICAL RECORDS RELEASE INFORMATION ~

Records From: Records To:

Name: ____ Name:____

Address: ____ Address : ____

City: ____ City : ____

Zip: ____ Zip: ____

Phone:______________________ Fax : ________________ Phone: _______________________ Fax : _________________

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the physician and/or employers of ____ to release medical information as indicated below.

Records Regarding:

Last Name: _______________________________________ First Name: ______________________________ Initial ______

Birth date: ___________________ SSN # ____________________________ Phone: ________________________________

Address: ____ City: _______________________________ Zip : ___________

Duration : This authorization shall become effective immediately and shall remain in effect until _________________________________ (enter date) or for one year from the date signature.

Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not effective to the extent that the requester or others have acted in reliance upon this authorization.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify Records: All medical records __________ Lab Results _________ Radiology ____________

ER reports ____________ Other ________________

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

Patient Signature: ____ Date: _____________________

Relationship if othe than patient: ____________________________________