HIPAA Release of Information Form

Individual/Patient Authorizing Release:

Name: *

Date of Birth: *

Address: *

City, State, Zip *

Phone: *

Email: *

Healthcare Provider/Facility Releasing Information:

Name of Provider or Practice: *

Address: *

City, State, Zip: *

Phone: *

Fax: *

Individual/Organization Receiving Information:

Name: *

Address: *

City, State, Zip: *

Phone: *

Fax: *

Information to Be Released:

Please release: *

- [ ] Entire medical record
- [ ] Specific records (specified below)
- [ ] Other (specified below)

Please specify records to be released here:

Purpose of Release

The release of my information will be used for the following specific purpose(s): *

- [ ] Planning appropriate treatment or program
- [ ] Continuing appropriate treatment or program
- [ ] Determining eligibility for benefits or program
- [ ] Case review
- [ ] Updating files
- [ ] Other

Please specify other purpose for release here:

Expiration of Authorization:

This authorization will expire upon: * specific date/event OR ongoing

Acknowledgement

By signing below, I confirm that I understand that I have the right to revoke this authorization at any time by providing written notice, except where action has already been taken based on this release. I also understand that my medical information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under HIPAA privacy regulations.

I authorize the release of my protected health information as specified in this document.

***Please note: if the patient is below the age of legal medical decision making in the state of Oregon and custody is shared between divorced parents, signatures from both parties are required on this form.**

Patient name *

Name of parent or guardian/authorized representative if applicable:

Signature: * ×

Date:

Name of second parent or guardian/authorized representative if applicable:

Signature: ×

Date: