Patient Authorization to Release Medical Records or Disclosure of Protected Health Information

OFFICE VISIT

Patient Name: _____

Date of Birth:_____ /_____ /_____ SSN: _____

Name of Individual Requesting Release: _____

Relationship to Patient:
- ☐ Self
- ☐ Parent/Guardian of minor
- ☐ Legal Counsel – Provide copy of legal representation document
- ☐ Other - specify: _____

Purpose of the Release: At the Request of the Patient

I hereby authorize you to release any medical records and/or medical information to the following individual(s):

1. Name: _____
   Address: _____
2. Name: _____
   Address: _____
3. Name: _____
   Address: _____

I understand that, in compliance with Privacy Act regulations (45 CFR 164.508(c)),

- I request and authorize release of medical records and/or medical information to the above named party or party's agent.
- This release is voluntary and I have the right to revoke this authorization at any time. My revocation must be provided to you in writing.
- I may refuse to sign this authorization and such refusal will not affect my treatment.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information.
- I have a right to a signed copy of this authorization.

This authorization shall expire on _____/_____/_____. If no date is provided, this authorization will expire one year from the date of signature/authorization indicated below..

_____ _____

Patient Signature Date of Signature/Authorization