HIPPA Medical Records Release Form

Name: ____
Last First Middle

Date of Birth: ___________________________ Phone: ____

Please give name and address of medical facility you are authorizing your medical records be released from:

Physician / Clinic: ____

Address: ____

Phone: __________________________________ FAX: __________________________________

I authorize ALL my medical records (Other Specify: _____________________________________) be released to:

Name: ____

Address: ____

Phone: _____________________________________ FAX: ____

Purpose of records being release are for continuation of care.

I understand that:

*I may refuse to sign this authorization and that my refusal has no impact on receiving treatment.
*I can inspect or copy any information disclosed under this agreement.
*My signing the document in voluntary.
*I can revoke authorization at any time, except to the extent that the practice has acted upon this authorization and revocation must be in writing.
*I can receive a copy of this authorization.
*Federal Laws will not cover information once it is released.

Patient/Legal Guardian Signature: ____Date: ____________

Identification of requestor of patient is verified by ________________________________