HIPAA Authorization Form

Patient Name	Date of Birth	Todays Date

Phone Number	Email Address

Authorization for Release of Health Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, hereby authorize _____ to release my health information as specified below to the individuals and/or entities named below. This authorization is granted for the purpose outlined herein.

1. **Authorized Recipient(s):**
   Please specify the name(s) of the individual(s) or entity(ies) who are authorized to receive the disclosed information:
   1. Name(s): _____
      Relationship to Patient: _____
   2. Name(s): _____
      Relationship to Patient: _____
   3. Name(s): _____
      Relationship to Patient: _____

2. **Health Information to Be Disclosed:**
   The following categories of health information may be disclosed:
   1. All medical and dental records relevant to my treatment.
   2. Insurance information and billing/payment details.
   3. Treatment plans, progress notes, and related health information.
3. **Purpose of Disclosure:**
   The information disclosed will be used for the following purposes:
   1. To process insurance claims and facilitate billing/payment.
   2. To provide necessary treatment and ensure continuity of care.
   3. For appointment reminders, follow-up care, or other healthcare communication needs.
4. **Expiration of Authorization:**
   This authorization will remain valid for **7 years** from the date of signature, unless revoked in writing earlier. If no expiration date is provided, the authorization will remain in effect until the purpose of the disclosure is fulfilled.
5. **Right to Revoke Authorization:**
   I understand that I have the right to revoke this authorization at any time by submitting a written request to _____ Revocation will not apply to any actions already taken based on this authorization prior to its revocation.

Patient Communication Preferences:

Please indicate your preferences regarding how we may communicate with you about your health information:

- ☐ **Phone:** I authorize _____ to contact me by phone at the number provided for health-related matters.
- ☐ **Email:** I authorize _____ to send me email communications concerning my health information at the address provided.
- ☐ **Text Message:** I authorize _____ to send text message communications to the phone number provided regarding my health information.
  Note: Standard text messaging rates may apply.

Acknowledgment of Understanding:

By signing this form, I acknowledge that I have been informed of my rights regarding the release of my health information. I understand that I may request a copy of this form for my records.

I also acknowledge that once my health information is disclosed to the authorized recipient(s), it may be subject to re-disclosure and may no longer be protected by HIPAA regulations.

Print Patient Name	Signature	Date

Print Witness Name	Witness Signature	Date

Disclosure of Liability:

I understand and agree that _____ is not liable for any incorrect or outdated information provided by me, the patient, or any of my representatives. This authorization is granted in compliance with the applicable laws and regulations of the state in which the practice operates. _____ will make all reasonable efforts to ensure that the information disclosed complies with relevant state and federal laws. However, once the information is released to the designated recipient(s), it is no longer under the control of _____ and may be subject to further use or disclosure by those recipients.