HIPAA Compliant Authorization for the Release of Patient Information

Pursuant to 45 CFR 164.508

Name: _____________________________________ Date of Birth:_______________________________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient and outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social work records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondences, photographs, videotapes, telephone messages, and records received by other medical providers.

All physical, occupational and rehab requests, consultations and progress notes

All autopsy, laboratory, histology, cytology, pathology, records and specimens; radiology records and films; nerve conduction studies, EKG and cardiac catheterization results; videos/CDs/films/reports

All pharmacy/prescriptions records including NDC numbers and drug information

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, HIV/AIDS and alcohol or drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CRF 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives:

Name: ____________________________________ Relationship:____

Phone number: (_____)_______-_______________

Name: ____________________________________ Relationship:____

Phone number: (_____)_______-_______________

Name: ____________________________________ Relationship:____

Phone number: (_____)_______-_______________

Patient/Guardian Signature____

Date: ___________________________