HIPAA Authorization Release Form

Patient Information

Patient Name

Date of Birth

Address

Recipient Information

Individual/Organization to Release Information To

Recipient Address

Information to be Released

Description of Information

Purpose of Disclosure

Purpose

Expiration

This authorization expires on (date or event):

Patient Rights

- This authorization is voluntary.
- You may revoke this authorization at any time by providing written notice.
- Refusal to sign this form will not affect your ability to obtain treatment.

Signature of Patient/Representative

Date

If signed by Representative, describe relationship to patient