HIPAA Authorization for Attorney Access to Records

Patient Name:

Date of Birth:

Attorney Name and Firm:

Attorney Address:

Healthcare Provider(s) Authorized to Release Records:

Information to be Disclosed:

- ☐ All medical records
- ☐ Billing records
- ☐ Other (specify):

Purpose of Disclosure:

Authorization Expiration Date or Event:

Patient Rights & Acknowledgment:

- I understand that I may revoke this authorization at any time in writing.
- I understand that the information disclosed may be subject to re-disclosure and no longer protected by HIPAA.
- I have the right to a copy of this authorization.

Signature of Patient or Personal Representative:

Date:

If Personal Representative, describe authority: