# HIPAA Authorization for Release of Medical Records

## Patient Information

Name

Date of Birth

Address

Phone Number

## Recipient Information

Name/Facility

Address

Phone Number

Fax Number

## Information to be Released

Description of Records

Date(s) of Service

Purpose of Disclosure

## Authorization

I authorize the release of my medical records as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing, except to the extent action has already been taken in reliance on this authorization.

Expiration Date/Event

Signature of Patient or Authorized Representative

Date

If not patient, relationship to patient