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HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/ Physician/ Facility

_____

Street Adress

_____

City, State and Zip Code Phone Number Fax Number

RE: **Patient Name:** _____

Date of Birth: _____

- ☐ **Summary of records to include: one year of lab results, one year of office notes and one year of radiology reports.**
- ☐ **Last lab result**
- ☐ **Last office note**
- ☐ **Other:** _____

I Understand:

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and 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 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR §164.508(c)(2)(I-iii)

1) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

2) The information released in response to this authorization may be re-disclosed to other parties.

3) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____ _____

Signature of Patient, or Legal Authorized Person Relation to Patient Date