

Template from signwren.com. General information, not legal advice. Check your state's rules and adapt it before you use it.

You do not need this form to get a copy of your own records. That is a right of access request, which is a separate process. Many providers require their own authorization form; ask first. Psychotherapy notes and records from federally assisted substance use disorder programs (42 CFR Part 2) need their own separate authorization or consent.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. Patient

Full name: [patient's full legal name]

Date of birth: [date]

Other names used in records: [former names, or "None"]

Address: [street, city, state, ZIP]

Phone / email: [contact details]

Patient ID or account number (if known): [number]

2. Who May Disclose the Information

I authorize the following person or organization to disclose my health information:

Name: [provider, hospital, clinic or health plan]

Address: [street, city, state, ZIP]

Phone / fax: [numbers]

3. Who May Receive the Information

The information may be disclosed to:

Name: [person or organization receiving the records]

Address: [street, city, state, ZIP]

Phone / email: [contact details]

Send the records by: ☐ Mail ☐ Secure email or portal ☐ Fax ☐ Pick up in person ☐ Other: [method]

Format: ☐ Paper ☐ Electronic copy

4. Information to Be Disclosed

Dates of service: from [date] to [date, or "present"]

- ☐ Office or clinic visit notes
- ☐ Hospital records (admission, discharge summary, operative reports)
- ☐ Laboratory and test results
- ☐ Imaging reports ☐ Imaging files
- ☐ Medication list and prescriptions
- ☐ Immunization records
- ☐ Billing and payment records
- ☐ Other (describe specifically): [description]

Specially protected information. Some laws give extra protection to certain kinds of records. Initial each item you specifically authorize for release. If you leave an item blank, it will not be released, where the law allows it to be held back.

- ____ Mental health records (not psychotherapy notes)
- ____ HIV or AIDS testing and treatment information
- ____ Genetic testing information
- ____ Other: [description]

This authorization does not cover psychotherapy notes. It does not cover records from a federally assisted substance use disorder program unless a separate consent that meets 42 CFR Part 2 is attached.

5. Purpose of the Disclosure

- ☐ At my request
- ☐ Continuing care with another provider
- ☐ Legal matter
- ☐ Insurance application or claim
- ☐ Disability or benefits claim
- ☐ Other: [purpose]

6. Expiration

This authorization expires on: ☐ [date] ☐ When this event occurs: [event, e.g. "my claim is closed"]

If no date or event is filled in, it expires one year from the date I sign it.

7. My Rights

I can revoke this authorization. I may revoke it at any time by sending a written, signed notice to the person or organization named in Section 2 at the address listed there. Revoking it will not undo any disclosure already made in reliance on this authorization. It also may not apply if I signed this authorization as a condition of getting insurance coverage and the law gives the insurer a right to contest a claim under the policy or the policy itself.

My care does not depend on signing. The person or organization named in Section 2 may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization, except where federal law allows it. If an exception applies, the consequence of refusing to sign is: [describe, or write "Not applicable"].

The information may be shared again. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law.

I get a copy. I am entitled to a copy of this signed authorization.

Fees. The person or organization disclosing the records may charge a fee allowed by law for copying and sending them.

8. Personal Representative

Complete this section only if someone other than the patient signs.

Name of representative: [full name]

Relationship or authority: ☐ Parent or legal guardian of a minor ☐ Health care agent under a power of attorney ☐ Court-appointed guardian or conservator ☐ Executor or administrator of the patient's estate ☐

Other: [describe]

Description of authority: [e.g. "Parent of the patient, who is 12 years old"]

Attach a copy of the document that gives you authority if the provider asks for it.

9. Electronic Signature

I agree that I may sign this authorization electronically, and that my electronic signature has the same effect as a handwritten one, unless the provider named in Section 2 requires a different method.

Signatures

Patient or Personal Representative

Signature: _____

Name: [full name]

Date: [date]