HIPAA AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Social Security #:** _____
_____
_____ **Phone Number:** _____

Date(s) of Service for requested information: _____

I hereby authorize (name and address of hospital/doctor's office that created the medical records): Place name of facility/Doctor in this section

_____
_____
_____

To release my medical records to (complete name, address and contact information):

_____
_____
_____

Please release the following information in my medical record (check all that apply):

- ▢ History & Physical
- ▢ Consultation Report(s)
- ▢ Discharge Summary
- ▢ Operative Report(s)
- ▢ Emergency Room Record
- ▢ Laboratory Report(s)
- ▢ X-Ray/Imaging Report(s)
- ▢ Abstract or Summary
- ▢ Entire Medical Record
- ▢ Other: _____ _____

Please release the following information in my medical record (check all that apply):

I ▢ do ▢ do not want HIV/AIDS information released under this authorization.

I ▢ do ▢ do not want mental health information released under this authorization.

I ▢ do ▢ do not want drug/alcohol abuse or treatment information released under this authorization.

I ▢ do ▢ do not want genetic testing information released under this authorization.

I ▢ do ▢ do not want sexually transmitted disease information released under this authorization.

The purpose for release of the above information is for:

▢ Continuation of Care ▢ Insurance ▢ Legal ▢ At my request (patient only) ▢ Other: _____

This authorization will expire within one (1) year. I understand that this authorization is voluntary and may be revoked by me at any time in writing by sending the written revocation to the facility in which I am requesting records, except to the extent that action has already been taken in reliance with this authorization. I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization of this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

_____
Signature of Patient or Patient's representative
(Personal & Legal Representative must include proof of status)

- ▢ Parent
- ▢ Personal Representative
- ▢ Legal Representative

_____
Date

_____
Witness

RETURN COMPLETED FORM TO: Iron Mountain

FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL BE RETURNED