HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

Patient's Name:_____ Date of Birth:_____

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI")

2. Authorization for release of PHI covering the period of health care
a. □ from (date) _____ - to (date)_____ OR
b □ all past, present and future periods.
c. my complete health record with the exception of the following information:

_____

Records to be sent/released: **SELF** or

Name:_____Relationship _____

Name:_____Relationship _____

Please mail to

Address:_____

City:_____ State:_____ Zip code:_____

Note: According to the Health Records Privacy Act a charge a $0.50 cents charge will be applied per page to the first 25 pages of ALL medical records. Any records that exceed 25 pages will be charged a $25 flat fee. After the initial request it will take between 48-72 hours for records to be reviewed and printed. Any records that need to be mailed will be charged a $10 shipping fee.

Signature:_____ Date:_____