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| HIPAA Release Form |
| This HIPAA Release Form authorizes the release of Protected Health Information (PHI) pursuant to 45 CFR §164.508. Please complete **all sections** using N/A if not applicable. If any sections are left blank, this form will be invalid. Page 1 of 2. |
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| Section 1 – Patient/Plan Member Information |  |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_ | First Name: \_\_\_\_\_\_\_\_\_\_\_ | Middle Name: \_\_\_\_\_\_\_\_\_\_ |  |
| Reference Nº: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_ |  |
| Section 2 - Individual/Organization Authorized by Signatory to Disclose PHI |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP:\_\_\_\_\_\_\_\_\_ |  |
| Section 3 - Individual/Organization Authorized by Signatory to Receive PHI |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Relationship to Patient/Plan Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP:\_\_\_\_\_\_\_\_\_ |  |
| Section 4 - Authorization Expiration Event or Date |  |
| Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing.  |  |
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| Expiration Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Section 5 – Health Information to be Disclosed - General  |  |
| I authorize the following Protected Health Information to be disclosed: |  |
| q Medical Records | q Dental Records | q Other Non-Specific |  |
| If Other Non-Specific, provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Section 6 – Health Information to be Disclosed – Specific |  |
| I authorize the following Protected Health Information to be disclosed: |  |
| q Communicable Disease | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Reproductive Health | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q HIV Test Results | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Mental Health Records | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Substance Use Disorder | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Other | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| If "Other", provide details: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Requests for psychotherapy notes require a separate HIPAA Release Form and may not be combined with any other request.** |  |
|  |
| q Psychotherapy Notes | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| Section 7 - Purpose of the Release or Use of Health Information |  |
| q Health Care q Research | q Marketing |  q Sale q Legal |  |
| q Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Note: The sale of PHI authorized by this HIPAA Release Form will result in remuneration to the party specified in Section 2. |  |
| Section 8 - Authorization Information |  |
| I understand the following: |  |   |  |
| 1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4. |  |
|  |
| 2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information from the date of receipt. |  |
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| 3. I am signing this authorization voluntarily and understand my entitlement to health care or health plan benefits will not be affected if I do not sign this HIPAA Authorization Form. |  |
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| 4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations. |  |
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| 5. I have a right to receive a copy of this HIPAA Authorization Form. |  |
| 6 (if applicable). My substance use disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization. |  |
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| Section 9 - Additional Conditions that Apply to this HIPAA Authorization Form |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Section 10 - Signature by or on Behalf of Patient/Plan Member |  |
| Name of Patient/Plan Member (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of signatory if not patient/plan member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Authority to sign on behalf of patient/plan member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of translator (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Signature of translator (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |