Standard Medical Information Release Form Template

This is an extra resource to go along with the original article:
Protecting your patient and practice: Creating and using a medical release form

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This document is only a sample. If you are a HIPAA Covered Entity, refer to your Institution's Privacy Policy document for specific information pertaining to HIPAA Authorization requirements and your business.

Patient Information

Patient's Name _____
Patient's Date of Birth _____
Patient's Address _____
Patient's Phone Number _____
Patient's Social Security Number _____
Parent/Guardian/Caregiver's Name _____

Receiver's Information

Receiver's Name _____
Receiver's Business _____
Receiver's Date of Birth _____
Receiver's Address _____
Receiver's Phone Number _____
Receiver's Title _____
Receiver's Email Address _____

Authorization Period

This authorization for release of information covers the period of healthcare from _____ to _____. (If left blank, the form will expire in 90 days from the date signed.)

Purpose of Release

Please check one.

- ❑ Social Security certification
- ❑ Medical disability claim
- ❑ Insurance claim

❑ Worker's compensation claim
❑ Inform child's school nurse
❑ College immunization notification
❑ Specialist consultation
❑ Other. Please explain: _____

Disclaimers

You may revoke this authorization at any time. Please send written notification of the revocation to _____. Your notice will not apply to actions taken by parties prior to your revocation date.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

If the receiving party is not a healthcare provider or health plan covered by federal privacy regulations, the information sent may be disclosed to parties who are not bound by healthcare regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

Signature

Patient or Representative Signature _____
Printed Name of Patient or Representative _____
Date _____