



HIPAA Release Authorization

I, _____, as a patient of _____, hereby authorize the release and disclosure of my protected health information (**PHI**) as defined by the Health Insurance Portability and Accountability Act (**HIPAA**) and its regulations.

The purpose of disclosure shall be; *(Please specify the purpose for which your PHI will be disclosed, such as medical treatment, insurance claims, legal proceedings, research, or any other specific purpose)*

The information shall only be disclosed to the recipients below;

Healthcare Providers

Health Insurance Companies

Business Associates

Family Members or Designated Representatives

Researchers

This HIPAA Release Authorization is valid starting the date of my signature below and remains in effect until _____. I have been informed and understand that I have the right to revoke this authorization at any time by providing written notice. However, any disclosures made prior to the revocation based on this authorization will remain valid.

I understand that my failure to sign or the cancellation of this authorization does not avoid from receiving treatment, enrollment, or eligibility for or benefits I am entitled to receive, provided the information herein shall not be required in determining whether I am eligible to receive treatments or benefits or to pay for the services I receive.

Name of the Patient

Date

Signature

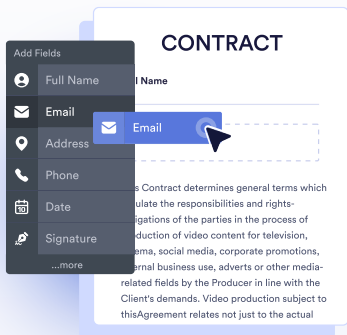


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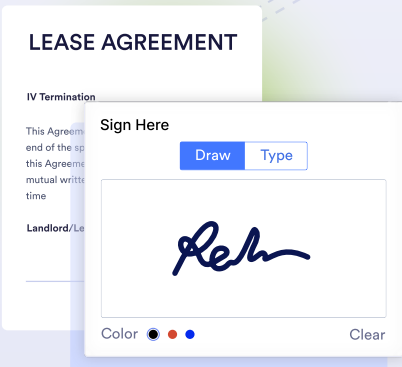
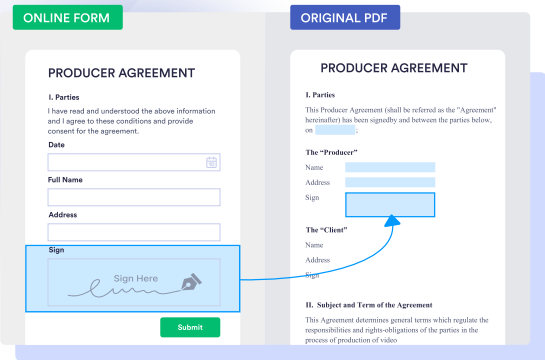
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