HIPAA AUTHORIZATION

Free fillable PDF • Let a chosen person see medical records • General nationwide draft

This is a free general nationwide draft from ForeverVault. It is not a state statutory form, not legal advice, and not a substitute for an attorney. Laws and signing rules differ by state. Have a licensed attorney in your state review this paper and follow that state's witnessing and notarization rules before you rely on it. ForeverVault LLC is not a law firm and does not represent you.

1. PATIENT

Patient full legal name

Street address

City / State / ZIP

Date of birth

Phone

Last 4 of SSN (optional)

2. WHO MAY RECEIVE MY RECORDS

Name of person or organization

Address

Phone

Relationship

3. WHO MAY RELEASE RECORDS

Provider, hospital, or health plan (or write All my health-care providers)

4. WHAT MAY BE RELEASED

- ☐ All medical records and billing records
- ☐ Visit notes and diagnoses
- ☐ Labs, imaging, and test results
- ☐ Medications and allergies
- ☐ Mental-health records (only if I check this and my state allows)
- ☐ Other, as I write below

Other records or limits

5. PURPOSE

- ☐ Coordinating my care
- ☐ Keeping my family or agent informed
- ☐ Legal or estate planning
- ☐ Other

Other purpose

6. WHEN THIS ENDS

☐ On the date I write here:

End date

☐ When this event happens:

Event

☐ One year from the date I sign, if I do not write another end

7. RIGHT TO REVOKE

I may revoke this authorization in writing, except to the extent a provider has already acted on it. Treatment, payment, or enrollment cannot be conditioned on signing this paper except as federal law allows.

8. SIGNATURE OF PATIENT

I understand the information released may be redisclosed by the recipient and may no longer be protected by HIPAA.

Date

State where signed

Patient signature

Printed name

If signed by a representative, describe authority (parent, agent, guardian)