

HIPAA Privacy Release of Information Authorization Form

I hereby authorize and request to furnish the protected health information of:

Social Security #:			DOB:	
	Phone			
Address:		City:	State:	
Vari manuriaa ay diaalaa	a tha fallawing bagith agus int	formantion (obook all	that amply).	
You may use or aisclos All my health informa	e the following health care inf	formation (<i>cneck all</i>	тпат арріу):	
All my health informa □ All my health informa				
☐ Mental Health Rec	•			
	iseases (including HIV or AIDS)	1		
☐ Alcohol/Drug abus				
☐ Lab Results				
☐ Other:				
	of PHI covering the period of he to (date)			
All past, present, and				
- 2.2.4 2.0004 31.10				
Reason for this authorize	ation:			
This soction is only ann	licable when records are beir	na rologood from one	organization/practice to an	athar
Release Records FRO I		ig released from one	organization/practice to ai	iotrier.
	WI.			
Nddreee:		City:	State:	
	Fax:			
	10/	Email.		
Send Records TO : Name:				
Send Records TO : Name: Address:		City:	State:	
Send Records TO : Name: Address:		City:	State:	
Send Records TO : Name: Address:		City:	State:	
Send Records TO : Name: Address: Phone:	Fax:Fax:Fax:Fax:Fax:	City:Email:Billing, condition, trec	State:state: _	
Send Records TO: Name: Address: Phone: I authorize disclosure o	Fax:Fax:Fax:Fax:	City: Email: billing, condition, trec ove to the following in	State: stment, and prognosis along ndividuals:	g with my PHI
Send Records TO: Name: Address: Phone: I authorize disclosure o	Fax:Fax:	City: City: Email: pilling, condition, trecove to the following in	State: stment, and prognosis along ndividuals: Relationship:	g with my PHI
Send Records TO: Name: Address: Phone: I authorize disclosure o	Fax:Fax:	City: City: Email: billing, condition, trecove to the following in	State: stment, and prognosis along ndividuals: Relationship: Relationship:	g with my PHI
Send Records TO: Name: Address: Phone: I authorize disclosure o Name: Name:	Fax:Fax:	City: Email: billing, condition, tred ove to the following in	state: stment, and prognosis along dividuals: Relationship: Relationship: Relationship:	g with my PH
Send Records TO: Name: Address: Phone: I authorize disclosure o Name: Name:	Fax:Fax:	City: Email: pilling, condition, tred ove to the following in	State: stment, and prognosis along ndividuals: Relationship: Relationship:	g with my PH
Send Records TO: Name: Address: Phone: I authorize disclosure o Name: Name: Name: Name:	Fax: of information regarding my b have selected abo Phone: Phone: Phone: Phone:	City: City: Email: pilling, condition, tree to the following in	State: stment, and prognosis along adividuals: Relationship: Relationship: Relationship: Relationship:	g with my PHI
Send Records TO: Name:	Fax:	City: City: Email: pilling, condition, trectore to the following in	state: State: atment, and prognosis along adividuals: Relationship:	g with my PHI
Send Records TO: Name: Address: Phone: I authorize disclosure of the content of	Fax:Fax:	City: Email: billing, condition, trecove to the following in t	state:	g with my PHI
Send Records TO: Name: Address: Phone: I authorize disclosure of the second state of	Fax: of information regarding my be have selected above. Phone: Phone: Phone: Phone: Phone: had understood the above, have had he above information or medical rison used or disclosed pursuant to see the second s	City: Email: billing, condition, trecove to the following in t	state: State: stment, and prognosis along adviduals: Relationship: Relationship: Relationship: Relationship: red to my satisfaction, and do he is to those persons or organization and disclosed by the recipient and the composition of the progners of the recipient and the composition of the progners of the recipient and the composition of the progners of the pro	g with my PH
Send Records TO: Name: Address: Phone: I authorize disclosure of the second and authorize disclosure of the understand that information.	Fax: of information regarding my b have selected abo Phone: Phone: Phone: Phone: ond understood the above, have hat the above information or medical interpretation used or disclosed pursuant to protected by	City: Email: Dilling, condition, tree ove to the following in a condition of the conditions answer records of my conditions this authorization may be condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the condition o	state: State: stment, and prognosis along adividuals: Relationship: Relationship: Relationship: red to my satisfaction, and do he so to those persons or organization and disclosed by the recipient and the state of the	g with my PHI
Send Records TO: Name: Address: Phone: I authorize disclosure of the control of	Fax: of information regarding my be have selected above. Phone: Phone: Phone: Phone: Phone: had understood the above, have had he above information or medical rison used or disclosed pursuant to see the second s	City: Email: Dilling, condition, tree ove to the following in a condition of the conditions answer records of my conditions this authorization may be condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the condition o	state: State: stment, and prognosis along adividuals: Relationship: Relationship: Relationship: red to my satisfaction, and do he so to those persons or organization and disclosed by the recipient and the state of the	ereby voluntarions listed above
Send Records TO: Name: Address: Phone: I authorize disclosure of the second and authorize disclosure of the understand that information.	Fax: of information regarding my b have selected abo Phone: Phone: Phone: Phone: ond understood the above, have hat the above information or medical interpretation used or disclosed pursuant to protected by	City: Email: Dilling, condition, tree ove to the following in a condition of the conditions answer records of my conditions this authorization may be condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the federal or state later than the condition of the condition o	state: State: stment, and prognosis along adividuals: Relationship: Relationship: Relationship: red to my satisfaction, and do he so to those persons or organization and disclosed by the recipient and the state of the	g with my PHI ereby voluntarions listed abov

Rev 12/22