

# HIPAA Compliant Authorization for Release of Information

I hereby authorize \_\_\_\_\_ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (including psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company for health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name	Date of Birth	Social Security Number
Dates(s) of Service (if known)	Medical Record Number	

Description of information to be released: (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Face Sheet           | <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Radiology Films (Imaging Department)         |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing Records (Patient Financial Services) |
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Pathology Reports  | <input type="checkbox"/> Other: _____                                 |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Diagnostic Reports | _____   |
| <input type="checkbox"/> Operative Reports    | <input type="checkbox"/> Emergency Room     | _____   |

The purpose of the disclosure is for the following: (check the appropriate category)

- Patient Request: (circle type of disclosure)**  
Hospital      Physician      Insurance      Attorney  
Other Please explain: \_\_\_\_\_

- Hospital Request:** Explain purpose of authorization \_\_\_\_\_

(If a hospital request, the patient must receive a copy of the authorization)

The information described herein will be sent to the following address: (if applicable)

**Capitol City Records Service, Inc. • 3303 Northland Dr. • Suite 200 • Austin, TX 78731**

I understand that this authorization will expire 180 days from the date of this authorization unless I otherwise specify.

I desire this authorization to be in effect until \_\_\_\_\_  
(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying said hospital in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient’s Representative	Date
Printed name of Patient’s Representative	
Relationship to Patient	Legal Authority (attach supporting documentation)