HIPAA Authorization to Release Protected Health Information

I, ________________________________ (Patient/Client Name), hereby authorize ____ (the "Covered Entity"/Former clinic) to release the following protected health information to the following individual(s) or entity for the stated purposes:

Name of Recipient(s)- **Information of New clinic:** ____

Address: ____

Phone: ____

Fax (PHI authorized to be sent via fax): ____

Relationship to Patient: ____

Information Authorized for Release:
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____
____

Purposes of the Release Authorized:
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____

Patient's email address: ____

This authorization shall expire one year from the date upon of its execution, unless earlier revoked by me or my personal representative. I understand I may revoke this authorization by providing written notice of such revocation to the Covered Entity identified above at any time. I understand that the Covered Entity will not condition my treatment, payment or enrollment/eligibility for benefits on whether I sign this authorization. I understand that it is possible that information disclosed pursuant to this authorization may be subject to re-disclosure by individuals who see it, and such individuals may not be bound by HIPAA. I understand that I will receive a copy of this authorization for my personal records.

____

Patient/Personal Representative Signature Date

November 2017