HEYMANN, MANDERS, GREEN & SOMMER, L.L.C.

HIPAA AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Health Care Provider (*Who has the information you want released?*)	Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
Receiving Party (*Where do you want the information sent? Who may have the information?*)	Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
Information to be Released (*What do you want sent or released? Check the appropriate box(es).*)	☐ Complete health record ☐ Biopsy Reports ☐ Lab Testing Reports ☐ Other: _____ ☐ For the following date range: From ___/___/_____ To ___/___/_____ OR ☐ For all dates of service
Purpose for Release (*Why is it needed?*)	☐ Continuing care ☐ Second opinion ☐ Research ☐ Disability ☐ Legal ☐ Insurance ☐ School Other: _____

- This authorization lasts for one year after the date you sign it unless you enter a different date here: _____
- This authorization may be canceled in writing at any time, by providing written notice to the releasing provider, attention to the Privacy Officer. A cancellation will not change releases that happen before the cancellation.
- The releasing provider will not restrict your treatment if you choose not to sign this authorization.
- A photocopy or other electronic copy of this authorization will be treated as an original.
- The releasing provider may have received health records from other providers which have been incorporated into your records at the releasing provider. If those records are included in those authorized above, they will be released.
- The releasing provider cannot prevent re-disclosure of your information by the person or organization that receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the releasing provider from any and all liability resulting from a disclosure by the recipient.
- Your signature below indicates you have read and understand this form, authorize release of your information as described above, and have received a copy of this authorization form.

Signed by: _____ _____
Signature of Individual or Legal Guardian/Legal Representative — Date

_____ _____
Print Name of Individual or Legal Guardian/Legal Representative — Relationship to Individual/Legal Authority

Main Office:	Cooper Office:
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