HIPAA Waiver Form

Authorization for the use or disclosure of protected health information · 45 CFR 164.508

1 Patient information

Patient Name: _____ **Date of Birth:** *mm / dd / yyyy*

Street Address: _____ **City, State, and ZIP Code:** _____

Medical Record Number (if known): _____ **Phone or Email:** _____

2 Who is authorized to release the information

The provider, practice, or facility that holds the records.

Name of Provider, Practice, or Facility: _____ **Phone or Fax:** _____

Street Address: _____ **City, State, and ZIP Code:** _____

3 Who is authorized to receive the information

Name a person, or a class of people such as "my treating cardiologist."

Name of Recipient: _____ **Relationship or Capacity:** _____

Street Address: _____ **City, State, and ZIP Code:** _____

Phone or Email: _____

4 Information to be released

Check every category you want released. Be as specific as you can.

- ☐ Complete medical record
- ☐ Office and progress notes
- ☐ Laboratory and pathology results
- ☐ Imaging reports and films
- ☐ Medication list and prescription records
- ☐ Immunization record
- ☐ Discharge summaries and operative reports
- ☐ Billing and claim records
- ☐ Treatment photographs or video
- ☐ Other (describe below)

Other information, or limits on the above:

Records dated from: _____ **To:** _____

Sensitive categories. These are protected separately. Initial only the ones you authorize.

_____ Mental health records and psychotherapy notes

_____ HIV, AIDS, or sexually transmitted infection

_____ Reproductive and fertility care

_____ Substance use disorder treatment (42 CFR Part 2)

_____ Genetic testing and family history

_____ Other: _____

5 Purpose of the disclosure

- [ ] At my own request
- [ ] Continuity of care with another provider
- [ ] Family member or caregiver involvement
- [ ] Insurance, benefits, or claim review
- [ ] Employer or workers' compensation
- [ ] Legal claim or attorney review
- [ ] School, camp, or sports program
- [ ] Second opinion
- [ ] Personal records or relocation
- [ ] Other (describe below)

Describe the purpose in your own words:

6 When this authorization ends

Fill in a date or an event. An authorization with neither is not valid.

This authorization expires on: *mm / dd / yyyy*

Or when this event happens:

7 What you should know before you sign

a. **You can change your mind.** You may revoke this authorization at any time. Put it in writing and send it to the practice named in section 2. Revoking it will not undo a release that already happened while it was in force.

b. **The recipient may share it again.** Once this information leaves the practice, the person or organization named in section 3 may redisclose it. At that point federal privacy rules no longer protect it.

c. **Your care does not depend on this form.** The practice cannot condition your treatment, payment, or eligibility for benefits on whether you sign. Research-related treatment is the one narrow exception.

d. **You will get a copy.** The practice will give you a copy of this form once it is signed.

8 Signature

Signature of Patient or Personal Representative:

Date: *mm / dd / yyyy*

Printed Name:

If signing for the patient, describe your legal authority:

For example: parent of a minor, court-appointed guardian, healthcare power of attorney, executor of the estate.

Witness Signature (if your practice requires one):

Date: *mm / dd / yyyy*

9 For office use only

Date Received:

Received By:

Copy Given to Patient On:

Expiration Logged in Record:

Authorization Reference Number:

Revoked On (if applicable):

This template is a starting point, not legal advice. State privacy laws can add requirements, so have counsel review your final version before you put it into use.