**CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION**

**(HIPAA Release)**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, hereby authorize the health care provider(s) named above to disclose to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name(s) of persons authorized to access my private health information*

any and all past, present, and future records, reports, or other information you have on file concerning my medical condition, specifically including records relating to

\_\_\_\_\_HIV/AIDS \_\_\_\_\_\_psychiatric or psychological treatment \_\_\_\_\_\_substance abuse   
*[initial above]*

I authorized my health care providers to discuss my medical care, treatment, and records with the person(s) named above.

The purpose of the release of information is personal support and assistance.

I understand that, once disclosed, my medical information will no longer be protected by the Health Insurance Portability and Accountability Act (“HIPAA”) and may be subject to redisclosure by the person(s) named above.

I understand my consent is revocable, except to the extent that action has already been taken; otherwise, this Consent remains in effect for one year from the date it was signed.

You are authorized and requested to accept this authorization, whether it bears an original or photostatic copy of my signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature

Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_