Medical Information Release Form (HIPAA Release Form)

Patient Name: ______________________________________ DOB: ____________________________

If patient is a minor, name of parent or legal guardian: _____________________________________

The Health Insurance Portability & Accountability Act is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential. Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name.

Please print name and relationship for each person to whom you are authorizing release of your private health care information and account balances.

____ ________________________________
Name Relation

____ ________________________________
Name Relation

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Name Relation

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Name Relation

I understand that authorizing the disclosure of my health information is voluntary. Furthermore, I understand I have the right to revoke this communication authorization at any time. Revocation of this authorization must be done in writing and presented to Coal Creek Family Medicine. Unless otherwise revoked, this authorization is **valid for one year** from date of signing.

____ ________________________
Patient/Parent or legal guardian signature Today's Date

Last revised 04/03/2019