

HIPAA RELEASE AND AUTHORIZATION

Patient's Name: _____

Address: _____

Date of Birth: _____

Social Security Number: XXX-XX-_____

Medical Records

I hereby authorize Tidewater Family Medical Care, PC ("Releasor") to use or disclose the following: (check one)

☐ **ALL Medical Records.** I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

☐ **Specific Medical Records:**

Recipient

My medical records shall be disclosed to the following individual or entity:

Name: _____ Contact: _____

Address: _____ Phone: _____

E-Mail: _____ Fax: _____

Purpose of Release: continuity of care

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Patient or Personal Representative Signature

Date

Printed Name

Personal Representative Relationship to Patient