FORM 9: Sample HIPAA Release

AUTHORIZATION FOR THE RELEASE AND/OR DISCUSSION OF MEDICAL RECORDS

Patient Information

Patient Name: _____

Social Security Number: _____

Birth Date: _____

Authorization

1. I, hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider.

2. To release to: LAW FIRM, ADDRESS

    • In emergency, release via fax _____

    • In emergency, do not release via FAX _____

3. The following information:

    • Complete Record

    • Outpatient Care Record

    • Inpatient Care Record

    • Test Results

    • Laboratory Results

    • Disability Information

4. If my record contains the following information, it is also released if INDICATED in boxes below:
    • Substance Abuse

    • Mental Health Treatment

    • HIV Testing or Treatment

5. The Information Release is for the purpose of: My claim for long term and/or short term disability benefits.

This form originally appeared in *An Attorney's Guide to ERISA Disability Claims.*

JP James Publishing
— AND ATTORNEY MARKETING —

Signature

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or organizations named above. I further release the agencies and/or clinicians named above from any liability arising from the release of this information, provided the said release of information is done substantially in accordance with applicable law.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization shall remain in force for 24 months following the date of my signature below.

It is understood that this information is confidential and should be treated as such by the parties herein named. I further understand that once this information is disclosed, it may no longer be protected by federal privacy rules and may be re-disclosed by the recipient.

A copy of this authorization is as valid as the original.

Signed: _____

CLIENT

Date:

_____/_____/_____