HIPAA AUTHORIZATION FORM

FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ______________________

Address: ______________________ Social Security Number – last 4 digits only: ____________

______________________ Email address: ______________________

______________________ Phone Number: ______________________

Date(s) of Service for requested information: ______________________

I hereby authorize Cariend to release my records from (name of original Provider/Facility that created the records):

____

____

To release my records to: ☐ Myself via electronic transfer ☐ Mailed to address below ☐ Contact Provider indicated below

____

____

Please release the following information in my medical record: ☐ Entire Medical Record (or select from list below)

☐ History & Physical
☐ Consultation Report(s)
☐ Discharge Summary
☐ Operative Report(s)
☐ Emergency Room Record
☐ Laboratory Report(s)
☐ X-Ray/Imaging Report(s)
☐ Abstract or Summary
Other: ____________
____
____

(Optional) Please release the following information in my medical record (check all that apply):

I ☐ do ☐ do not want HIV/AIDS information release under this authorization.
I ☐ do ☐ do not want mental health information released under this authorization.
I ☐ do ☐ do not want drug/alcohol abuse or treatment information released under this authorization.
I ☐ do ☐ do not want genetic testing information released under this authorization.
I ☐ do ☐ do not want sexually transmitted disease information released under this authorization.

The purpose for release of the above information is for:

☐ Continuation of Care
☐ Insurance
☐ Legal
☐ At my request (patient only)
☐ Other: ____________

This authorization will expire within one (1) year unless otherwise indicated. I understand that this authorization is voluntary and may be revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization. I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization for this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

PLEASE PROVIDE A COPY OF PHOTO IDENTIFICATION WITH THIS RELEASE FORM

____
Signature of Patient or Patient's representative
(Representative must include proof of status)

☐ Parent/Guardian
☐ Personal Representative
☐ Legal Representative

____
Request Date

FORM MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST WILL NOT BE PROCESSED

IF MAILING: CARIEND - PO BOX 1866 - THOMASVILLE, GA 31799

© 2020 Cariend, LLC. All rights reserved.