Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ Date of Birth: _____

Address:

_____

Email Address: _____ Phone Number

_____

Release of Information

I hereby authorize the release of my protected health information in accordance with and in the manner described hereafter.

Release Information To:

Name: _____

Address:

_____

Email Address: _____ Phone Number

_____

Purpose of Release:

__ Continuing Medical Care __ Work Comp __ Disability Determination

__ Personal __ Insurance Claim __ Application for Insurance __ Legal

__ Other: _____

Delivery Method:

1. __ Paper via __ Mail **OR** __ Pick Up
2. __ Electronic via Email

Information to be Released:

__ Diagnosis	__ Examination Records	__ Claim Information
__ Clinic Visit Notes	__ History and Physical	__ Billing Statements
__ Immunization Records	__ Lab Reports	__ Entire Medical Record
__ Other: _____		

Duration of Release:

__ No Expiration Date	__ One Year	__ On Following Date ____/____/_____
__Other: _____		

I understand this ***Release of Information*** will remain in effect for the duration specified above unless earlier terminated by me in a writing delivered to Stellar Healthcare. I understand that in the event that my information has already been disclosed by the time my release is revoked, it may be too late to cancel such disclosure. I understand that the failure to sign this authorization or the subsequent termination of this release will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Signature: _____
Date: _____

Relationship of Person Signing

_____