REQUEST FOR MEDICAL RECORDS RELEASE
HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize_____(healthcare provider) to use and disclose the protected health information described below to **MD Diet/Serenity MD.**

This authorization for release of information covers the period of healthcare from _____to_____.

I authorize the release of the following:

*** Laboratory Studies**
*** Cardiac Studies**
*** Other _____**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign the authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of Patient Date

_____

Print name of Patient Date of Birth

Location _____

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