Signature Healthcare of Volusia
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HIPAA Release of Information Form

Please complete all sections of this HIPAA release of information form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I, _____, (Print Patient Name)

D.O.B. : _____ S.S. # _____

give my permission for _____

_____

_____

to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Mark as appropriate -

❑ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

OR

❑ Disclose my complete health record **except** for the following information

- ❑ Mental health records ❑ Alcohol/drug abuse treatment records
- ❑ Communicable diseases including, but not limited to, HIV and AIDS
- ❑ Genetic information ❑ Other (Specify)_____

_____

Section III – Reason for Disclosure

Please give the reason why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name / Organization Receiving my information: _____

_____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid through: ____ / ____ / _____ (MM/DD/YR)

Section VI – Signature

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Relationship to patient: _____