HIPAA (Health Insurance Portability and Accountability Act) Release

I, ____ (person or patient naming agent), intend for any agent named in this release to be treated as I would be treated as I would be treated with respect to my rights regarding the us and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following persons:

NAME (FIRST AND LAST)	ADDRESS	RELATION TO PATIENT

Name: ____ Date: ________________________

Signature: ______________________________________