Sharing My Medical Information

(*Plain Language HIPAA Authorization for Disclosure of Health Information*)

My name is ____.

My doctor's office or hospital is called: __________________________________.

It is in this city: ____.

My doctors and nurses write notes about me. They also write about the tests they do. These notes are called **records.**

I want to share my medical records**.**

The person who can see my records is:

Name: ____

Address: ____

Phone number: ________________________________

Email address: ____

This person can see:
Check one box.

☐ All of my medical records.
☐ Only some records. The records this person **can see** are:

____

____

Write what records you want the person to see.

This person can see my records until:
Check one box.

☐ This date: ___________________________.

☐ When I sign a form to say that this person can no longer see my records.

I have decided to share my medical records with ___________________________.
I know that I do not have to share these records.

I know that I can stop this agreement at any time.

My doctors and nurses have to be very careful with my medical records. They cannot usually show my records to other people. The person who I am sharing my records with cannot share them with other people unless I agree.

I trust the person I am sharing my records with.

My signature:

____

The date today is: ____.