HIPAA Authorization

(Plain Language HIPAA Authorization for Disclosure of Health Information, adapted from the ACLU)

Sharing My Medical 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: *(Select one)*

☐ 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: *(Select one)*

☐ This date: _____ .

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

I know these records are usually kept private. I have chosen to share them with the supporter I named above.

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.

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

My signature: _____

Today's date is: _____