BLUE RIVER
Family Medicine

HIPAA Privacy Authorization Form

Authorization for Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Authorization to Disclose Medical Information:

I voluntarily authorize Blue River Family Medicine to release my medical information to me in the following way (please circle):

Voicemail *Patient Portal* *All* *None of these*

Recipient:

I voluntarily authorize Blue River Family Medicine to disclose my health information to the recipient(s) that I have identified below:

1. Name & Relationship: _____ Phone#_____

2. Name & Relationship: _____ Phone#_____

3. Name & Relationship: _____ Phone#_____

Information to be Disclosed:

I authorize the release of the following health information (check the applicable box below):

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history and/or mental or physical condition.

☐ Any billing, insurance, or claim information associated with my care.

☐ Only the following records or types of health information:

_____

_____.

Patient/Guardian Signature: _____ Date: _____