HIPAA Medical Information Release Form

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone Number: _____ Email: _____

I authorize the use and disclosure of my protected health information as described below:

The following individual(s) or organization(s) are authorized to receive my medical information:
Name/Organization: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone Number: _____ Fax Number (if applicable): _____

The following healthcare provider/facility is authorized to disclose my medical information:
IV League Pharmacy 6076 Bristol Parkway Suite 104 Culver City, CA 90230
Phone Number: 310-645-1500 Fax Number: 310-645-6464

Purpose of Disclosure:
☐ Personal use ☐ Continued medical care
☐ Insurance ☐ Legal purposes
☐ Other (please specify): _____

Description of Information to Be Disclosed:
☐ Entire medical record
☐ Specific information (select all that apply):
- ☐ Lab results
- ☐ Imaging reports
- ☐ Medication history
- ☐ Immunization records
- ☐ Treatment summaries
- ☐ Other (please specify): _____

This authorization will expire:
☐ Upon completion of the requested disclosure ☐ On this date: _____
☐ Other (please specify): _____

Patient Rights: I understand that I have the right to revoke this authorization at any time by providing written notice to the healthcare provider listed below, except to the extent that action has already been taken in reliance on this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this form unless allowed by law. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

I have read and understand this authorization. I confirm that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____ Date: _____

If Signed by Legal Representative:
Name: _____ Relationship to Patient: _____

For Internal Use Only:
Date Request Received: _____ Date Information Released: _____
Processed By: _____