Request for Release of Protected Health Information (HIPAA)

This form will be used to release your protected health information as required by federal and state privacy laws. Your authorization allows Paradigm Hormones to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Paradigm Hormones. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Your Information:

Name: _____

Address: _____

City/St/Zip: _____

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

SSN: _____

I authorize my physicians, medical professionals, Paradigm Hormones, and its agents and affiliates to release my protected health information as described below:

Recipient: _____

Relationship: _____ Phone Number: _____

Address: _____

City/St/Zip: _____

Manner of Release:

- ☐ Records shall be made available for Pick-up only.
- ☐ Records shall be mailed to recipient to: _____
- ☐ Records shall be faxed to recipient to: _____
- ☐ Records shall be emailed to recipient : _____
- ☐ Any of the above

Description of information to be released:

- ☐ All information related to the provision of payment for my healthcare benefits or services.
- ☐ Specific information as described on the line: _____

Purpose of Release:

_____

_____

This authorization will expire (Check only one box)

- ☐ When I revoke this authorization
- ☐ Up the following date, event or condition: _____

Information regarding approval:

You or your personal representative must sign and date this form in order for it to be complete. A personal representative is a person who authorizes the release of protected health information and has the legal authority to act on behalf of an individual. To release information to a personal representative, we must have a copy of a power of attorney or other legal document on file at the time of the request to release information to the personal representative.

Affirmation and Request for Release of Information:

"I affirm all the foregoing and information supplied herein is true and correct. I further understand that this authorization to release information voluntary and is not a condition of treatment, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws. I request that Paradigm Hormones release the protected health information described above to the persons and/or entities listed above for the purposes set forth above."

_____ _____

Signature **Date**