DEVON FAMILY PRACTICE

HIPAA RELEASE FORM

Patient's Name: _____

Date of Birth: _____ Phone: _____

According to the Health Insurance Portability Accountability Act (HIPAA) regulations, we are required to keep your health information confidential. You have the right to restrict family members or other persons from accessing your health information. However, we are aware that many of our patients do not wish to restrict their spouse, family member, or other person from having access to their health information. In an effort to comply with HIPAA regulations, and to avoid inconveniences for our patients we are asking that you please complete this form. If at any time you wish to change any of the information on this form, please notify our office in writing.

The parents or legal guardians of a minor will always have access to medical information. In the case you would like to designate additional individuals to have this access, please list them below. Health information would include your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment, and procedures). You are not required to list anyone, but if you do, you are authorizing that person to have complete access to your medical and/or payment information.

Please mark the type of access you would like them to have.

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Obtain/ Authorize Release of Medical Records

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Obtain/ Authorize Release of Medical Records

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Obtain/ Authorize Release of Medical Records

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Name: _____

(please print)

Patient Signature: _____ Date Signed: _____