



**HIPAA COMPLIANT AUTHORIZATION FOR  
RELEASE OF PATIENT INFORMATION**

Please fully complete and sign the following form to provide HIPAA compliant authorization for PMR Healthcare to share your health record. Once fully completed and signed, you should submit the entirety of this form to PMR Healthcare:

1. Before 6/30 – scan the completed form and email it to [pmrhagadonecda@pmrhealthcare.com](mailto:pmrhagadonecda@pmrhealthcare.com)
2. After 7/1 – scan the completed form and email to [RecordRequest@PMRHealthcare.com](mailto:RecordRequest@PMRHealthcare.com)

PMR Healthcare will contact you if there are any issues or missing information in the submitted forms.

Contact phone number: \_\_\_\_\_

Contact email: \_\_\_\_\_

**PLEASE PRINT LEGIBLY**

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Patient Last 4 SSN: \_\_\_\_\_  
mm/dd/yyyy

I authorize and request the disclosure of all protected information for the purpose of reviewing and documentation of my health history. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- All physical, occupational and rehab requests, consultations, and progress notes.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information with full consent under 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

This protected health information is disclosed for the following purposes: \_\_\_\_\_

\_\_\_\_\_



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**You are authorized to release the above records to the following:**

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Name of Organization/Company/Individual

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Email

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Street Address

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City, State and Zip Code

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Phone Number

Fax Number

I understand the following:

- A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- B. The information released in response to this authorization may be re-disclosed to other parties.
- C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

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Signature of Patient or Legally Authorized Representative

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Date

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Name and Relationship of Legally Authorized Representative to Patient