

# HIPAA RELEASE AND AUTHORIZATION

Patient's Name:  Date of Birth:

Address:  Social Security #:

**Medical Records.** I hereby authorize **Monmouth County Sheriff's Office** ("Releasor") to use or disclose the following: (check one)

**ALL Medical Records.** I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

**Restrictions** Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

- Be Included.
- NOT Be Included.

**Specific Medical Records:**

**Recipient.** My medical records shall be disclosed to the following individual or entity:

Name:  Contact:

Address:  Phone:

E-Mail:  Fax:

**Purpose of Release:**

**Expiration.** This authorization expires on:

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

\_\_\_\_\_  
**Patient or Personal Representative Signature**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name