

## Sharing My Medical Information

*(Plain Language HIPAA Authorization for Disclosure of Health Information)*

*A Note to Providers/ Records Departments: Per the Americans with Disabilities Act, individuals with disabilities are able to use simplified versions of forms to request or grant permission for others to access their information as a reasonable accommodation. There are no federal or state mandated forms for HIPAA Authorization. This form stands as a valid a means for the individual named below to request information and grant permission for others to access their information as detailed below.*

My name is: \_\_\_\_\_.

My doctor's office or hospital is called: \_\_\_\_\_.

It is in this city: \_\_\_\_\_.

My doctors and nurses write notes about me. They also write about the tests they do. These notes are called **records**.

I want to share my medical records.

The person who can see my records is:

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

This person can see: *(Check one box.)*

- All of my medical records.
- Only some records. The records this person **can see** are:

*(Write what records you want the person to see.)*

\_\_\_\_\_

\_\_\_\_\_

This person can see my records until: *(Check one box.)*

This date: \_\_\_\_\_.

When I sign a form to say that this person can no longer see my records.

I have decided to share my medical records with: \_\_\_\_\_.

I know that I do not have to share these records.

I know that I can stop this agreement at any time.

My doctors and nurses have to be very careful with my medical records. They cannot usually show my records to other people. The person who I am sharing my records with cannot share them with other people unless I agree.

I trust the person I am sharing my records with.

My signature:

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The date today is:

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