

**HOSPITAL VISITATION AUTHORIZATION
AND HIPAA RELEASE (Sample)**

Patient Name: _____

Date of Birth: _____

I direct that the individuals listed below are authorized to visit me in any health care facility, including hospitals, skilled nursing facilities, and residential care settings, to the fullest extent permitted by law.

I authorize health care providers and their staff to disclose to the individuals listed below information regarding my physical or mental condition, treatment, and care, including protected health information, as reasonably necessary to facilitate visitation and involvement in my care.

This authorization supplements any Advance Health Care Directive or other health care instructions I have executed. If there is any uncertainty, I direct that this document be interpreted to allow access and visitation for the individuals named below, regardless of whether they are related to me.

Authorized Individuals

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

This authorization is effective immediately and remains in effect unless revoked in writing.

Signature: _____

Date: _____

Sample form for educational purposes only. Practitioners should tailor documents to client needs and applicable law. Conceptually grounded in California Advance Health Care Directive law (Cal. Prob. Code §§ 4670–4678), HIPAA (45 CFR § 164.510), and federal hospital visitation regulations (42 CFR § 482.13). Add a Notarization block or spaces for two witness signatures.

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