Medical Information Release Form
(HIPAA Release Form)

Name: ____________________ Date of Birth: ___/___/___

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ______________________________

[ ] Child(ren) ______________________________

[ ] Other ______________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell #: ______________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other ______________________________

The best time to reach me is (*day*) ______________ between (*time*) __________

Signed: ______________________________ Date: ___/___/___
Witness: ______________________________ Date: ___/___/___