Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth:___/____/_____

Release Information

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

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Physician_____

[ ] Other_____

[ ] Information is not to be release 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 number _____

If unable to reach me:

[ ] you may leave a detailed message

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

[ ] _____

The best time to reach me is (day)_____between (time)_____

Signed_____ Date: ____/____/____