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 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: ____/____/_____

Witness:_____   Date: ___/____/_____