Medical Information Release Form

(HIPAA Release Form)

Patient 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 is information may be released to:

1. Spouse: _____
2. Child(ren): _____
3. 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: _____ [ ] Home [ ] Cell [ ] Work

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: ___/___/_____