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
( ) you leave a message asking me to return your call
( ) _____

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

Signed_____Date____/___/_____

Witness_____Date____/___/_____