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:_____