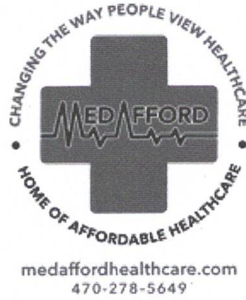

Medical Information Release Form
(HIPAA Release Form)

Patient's Name: ____

Patient's 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: Name: ________________________________ Phone:____________________

[ ] Child(ren): Name(s): ____________________________ Phone:____________________

[ ] Other: Name/Relationship: _______________________ Phone: ____________________

[ ] My medical information is not to be released to anyone other than myself.

If the clinic is unable to reach me:

[ ] You may leave a detailed message with medically sensitive information on my voicemail.

[ ] Please leave a message asking me to return your call. I do not consent to my personal medical information to be left on a voicemail.

The best time of day to reach me is (Please circle one):

Morning (9am-11am) / Afternoon (12pm-3pm) / Early evening (4pm-5pm) / Any time

The best day of the week to reach me is:

Monday / Tuesday / Wednesday / Thursday / Friday / Any day

* This **Release of Information** will remain in effect until terminated by me in writing.*

Patient's signature : ______________________________________ Date: _____/_____/_____

Witness' signature:_______________________________________ Date: _____/_____/_____