The Geraldine Clinic, LLC

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:

Name:_____ Phone Number:_____
Name:_____ Phone Number:_____
Name:_____ Phone Number:_____

[ ] 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 phone [ ] work phone [ ] cell phone:_____
If unable to reach me:

[ ] you may leave detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is [ ] day [ ] noon [ ] evening

Signed:_____ Date:____/____/____
Staff signature:_____ Date:____/____/____

Patient ID #_____