Tel: 817-769-6339
Fax: 817-719-9336
Email: pshealthservices1@gmail.com

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/from:

[ ] Name _____ Relation _____

[ ] Doctor and Hospital

[ ] I agree that 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

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

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____