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:_____________________________ Phone Number:__________________

[ ] Child(ren):__________________________ Phone Number:__________________

[ ] Other:______________________________ 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 [ ] 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

[ ] ____

The best time to reach me is (day)____________________ between (time) __________________

Signed: ______________________________________ Date: _______ /_______ /__________

Witness: _____________________________________ Date: _______ /_______ /__________