HIPAA Release Form

Premier Cardiovascular Institute

Patient Name: _____ **Data 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 ----------
- ✓ Infomation 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 eave a detailed message
- ✓ please leave a message asking me to return your call
- ✓ do not leave a message

Signature: ---------- Date: ----------