



## HIPAA General Medical Release Form

**I hereby authorize the disclosure of my medical information by ASTER CLINIC Medical Group :**

**Person authorizing release of information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

**To release my information to:**

Name/Relationship \_\_\_\_\_ DOB: \_\_\_\_\_

Name/Relationship \_\_\_\_\_ DOB: \_\_\_\_\_

Name/Relationship \_\_\_\_\_ DOB: \_\_\_\_\_

Name/Relationship \_\_\_\_\_ DOB: \_\_\_\_\_

**This authorization applies to the following: (check all that apply)**

All Records

Labs

Imaging Reports

Immunizations

Name (Printed): \_\_\_\_\_

Signature : \_\_\_\_\_ Date: \_\_\_\_\_