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**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 release to:

Spouse Name: \_\_\_\_\_

Child(ren) Name(s): \_\_\_\_\_

Other Names (s): \_\_\_\_\_

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: \_\_\_\_\_

If unable to reach me:

please leave a message asking me to return your call

\_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_