Medical Information Release Form
HIPAA Release Form

Patient 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: _____/____/_____