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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 released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] 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: ___/____/_____