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 release 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.

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call

[ ] _____

Signed _____ Date ___/___/___