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

☐ Other: _____

The best time of day to reach me is: (day)_____ between (time)_____

Signed: _____Date: _____/_____/_____

Witness:_____Date:_____/_____/_____