Medical Information Release Form
(HIPAA RELEASE FORM)

Name: _____Date of Birth: ____ /____/_____

Release Information:

[ ] I authorize the release of my information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Significant Other: _____

[ ] Child(ren): _____

[ ] Parents: _____

[ ] Other: _____

[ ] Information is not to be release to anyone

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.

The best time to reach me is (day) _____between (time) _____

Patient/Guardian Signature: X_____ Date: ___/___/____

Witness: _____ Date: ___/___/____

This ***Release of Information*** will remain in effect until terminated by me in writing.