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 _____
- ☐ Children _____
- ☐ 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: ☐ Home _____ ☐ Cell phone _____ ☐ Work _____

If you are unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message to return the call
- ☐ _____

The best time of day to reach me is:

- ☐ Day
- ☐ Night

Time: _____

Signature: _____ Date: _____

Witness: _____ Date: _____