



Medical Information Release Form (HIPAA Release Form)

Name _____

Date of Birth _____

Release 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 to not 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 _____