HIPAA Authorization 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 release 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 phone

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 to reach me is: (day) _____ between (time) _____

Signed: _____ Date: ____ / ____ / ____

Witness: _____ Date: ____ / ____ / ____