CFM
Compassionate Family Medicine

MEDICAL INFORMATION (HIPAA) RELEASE FORM

Patient Name *(first, middle, last)*	**Date of Birth** *(mm/dd/yyyy)*	**Social Security Number**
Email Address	**Preferred Language**	**Gender** [ ] F [ ] M [ ] Other
Address		
Home Phone	**Cell Phone**	**Work Phone**
Emergency Contact *(Name / Relationship)*		**Phone Number**
Insurance Carrier	**Policy Holder Name**	
Policy Number	**Policy Holder SSN**	
Pharmacy *(Name / Address)*	**Pharmacy Phone Number**	

Release of Medical Information

Note: This Release of Information will remain in effect until terminated by the patient in writing.

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

[ ] Spouse / Other: _____ Phone # _____
[ ] Adult Child(ren): _____ Phone # _____
[ ] Parent Name: _____ Phone # _____
[ ] Other Name: _____ Phone # _____

[ ] Information is **not** to be released to anyone.

Messages

Leave appointment message on:	Y	N
Home Phone including automated service?		
Mobile Phone including automated service?		
Mobile Text including automated service?		
Work Phone?		
With another person? List name below:		
Send via mail?		
Send via Email / Portal?		

Leave medical information on:	Y	N
Home Phone including automated service?		
Mobile Phone including automated service?		
Mobile Text including automated service?		
Work Phone?		
With another person? List name below:		
Send via mail?		
Send via Email / Portal?		

I acknowledge that I have been given the opportunity to read and/or receive a copy Compassionate Family Medicine's Notice of Privacy Practices: [ ] Yes [ ] No

I consent to have the Practice use and disclose my protected health information for payment, treatment, and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signed: _____ **Date**: _____/_____/_____

I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signed: _____ **Date**: _____/_____/_____