Medical Information Release Form

HIPAA Release Form

Name _____ DOB_____

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 _____

_____ Child(ren) _____

_____ Other _____

_____ Information is not to 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 phone_____

If unable to reach me: _____you may leave a detailed message
_____please leave a message asking me to return your call
_____do not leave a message

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

Signature _____ Date _____

Signature of Parent/Guardian _____