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 released to anyone.

Messages

Please call: [ ] my home [ ] my work [ ] my cell

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: ____/____/____