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 may be release 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 Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] You may text information to my cell [ ] You may email information to me

Signed:_____Date: ____/____/_____

Witness:_____Date:____/____/_____