Medical Information Release Form
(HIPPA Release Form)

Name:____ Date of Birth:____/____/____

Release of Information

[ ] I authorize the release of information including 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 number ____________________

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:_____/____/_______