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 in formation 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:_____

[ ] It is okay to text detailed information at _____

If unable to reach me:

[ ] you may leave a detailed message

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

[ ] you may send me a detailed text message

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

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

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