



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_

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: ____/____/____