Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

☐ I authorized 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: _____/_____/_____