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(s)_____

☐ 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
- ☐ leave a message asking me to return your call
- ☐ Other instruction: _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____