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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)_____

PCP_____

_____

[ ] 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

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____