Medical Information Release Form

(HIPAA Release Form)

Patient Name: _____ Date of Birth: ____/ ____ / ____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination and insurance claim information for the above named patient. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Parents _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Informtaion*** 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) _____

Signature: _____ Date: _____ / _____ / ____