Medical Information Release Form

(HIPAA RELASE FORM)

Name:_____ DOB: _____

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

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) _____