Medical Information Release Form

(HIPAA Release Form)

Name: ____

Date of Birth: ______________________________________

I authorize the release of information including 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:

- ☐ Home
- ☐ Cell Phone
- ☐ Work
- ☐ Email

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ ____

Signed: ____ Date: ______________________