Medical Information Release Form
(HIPAA Release Form)

Name: _____ DOB: ____/____/____

Release 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 _____ □work _____ □cell number _____
If unable to reach me:

□ you may leave a detailed message
□ please leave a message asking me to return your call
□ other _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____