Medical Information Release Form

(HIPAA Release Form)

Patient Name: ______________________________ Date of Birth: _________________________

Release of Information

Other than my referring physician:

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. Upon request, this information may be released to:

- ☐ Spouse____
- ☐ Child(ren)____
- ☐ Other ____
  - ☐ Fax ______________________________________
  - ☐ Mail ______________________________________
  - ☐ Email _____________________________________

OR

☐ 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
- ☐ ____

Signed: ______________________________ Date: ______________________________

Witness: ______________________________ Date: ______________________________