

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information, including the diagnosis, medical records/reports, examination rendered to me and claims information. This information may be released to:

My email address _____

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 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: ____/____/____

Witness: _____ Date: ____/____/____