Medical Information Release Form

(HIPPA Release Form)

Name: _________________________________ **Date of Birth:** _________________________

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 ______________________________
- ☐ Children ______________________________
- ☐ Other ________________________________

☐ Information is not to be release to anyone.

This release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ Home _________________ ☐ Cell phone ___________________ ☐ Work ______________________

If you are unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message to return the call
- ☐ ___________________________________

The best time of day to reach me is:

- ☐ Day
- ☐ Night

Time: _________

Signature: ____ Date: __________________________________

Witness: ____ Date: __________________________________