# *Medical Information Release Form*

## *(HIPAA 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_____
- ☐ 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*)_____

PLEASE PRINT THE COMPLETED FORM AND THEN SIGN AND DATE IT AND BRING IT TO YOUR APPOINTMENT

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

**(Optional)**