Medical Information Release Form

(HIPPA Release Form)

Name: _____ **Date of Birth:** ____/___/____

Release of Information

[ ] I authorize the release of information including the diagnosis, record; examination rendered to me and claims information. This information may be released to:

Name of Spouse _____

Name of Child(ren) _____

Name of 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)*_____

Signed: _____ Date:___/___/____

Witness: _____ Date:___/___/____