Medical Information Release Form

(HIPAA Release Form)

Name:_________________________________ Date of Birth: __________

Release of Information

[ ] You may call or text me at: ____________________________

[ ] You may leave a detailed message

OR

[ ] You may leave a message asking me to return the call

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

Name: ___________________________ Relationship: __________________

Phone: ____________________

Name: ___________________________ Relationship: __________________

Phone: ____________________

Name: ___________________________ Relationship: __________________

Phone: ____________________

[ ] Information is not to be released to anyone.

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

Signed: ____ Date: _____/_____/_____

Staff Witness: ___________________________________ Date: _____/_____/_____