# 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, claims information and appointment 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

( ) ___________________________________________

Signed: ___________________________________________ Date: ___ / ___ / ___

Witness: __________________________________________ Date: ___ / ___ / ___