Medical Information Release Form

HIPAA Release Form

Patient/Patients:

Name____ **Date of Birth**____________

Name____ **Date of Birth**____________

Name____ **Date of Birth**____________

Name____ **Date of Birth**____________

RELEASE OF INFORMATION

[ ] I authorize the release of information including diagnosis, records, examination and claim information rendered to the above listed patients to me and the following individuals:

[ ] Parent/Guardian Name_______________________________________

[ ] Self____

[ ] Other____

[ ] Information is not to be released to anyone.

The R**elease of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] work [ ] cell at: __________________________

If unable to reach me you may:

[ ] leave a detailed message

[ ] not leave a message and call back

[ ] leave a message asking me to return your call

Signed: _______________________________________Date______________

Witness: ______________________________________Date______________