<u>*Medical Information Release Form*</u>

<u>*(HIPAA Release Form)*</u>

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

<u>*Release of Information*</u>

[ ]   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.

<u>*Messages*</u>

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: ___/___/____