Medical Information Release Form
(HIPPA Release Form)

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

Release of Information

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

[ ] Spouse/Partner ______________________________

[ ] 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

[ ] you may leave a message with people listed above.

[ ] other ______________________________

Print name: ______________________________ **Date** ____/____/____
Sign: ______________________________ **Date** ____/____/____
Witness: ______________________________ **Date** ____/____/____