Medical Information Release

Form (HIPAA Release Form)

Patient's Name:_____ **Date of Birth:**_____

Release of Information

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

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Information should **NOT** be released to:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

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

Messages

If unable to reach me:
☐ you may leave a detailed message
☐ please leave a message asking for me to return your call
☐ _____

Signature:_____ **Relationship:**_____ **Date:**_____

Witness:_____ **Date:**_____