

# 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 claims information. This information may be release 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

other \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_