Medical Information Release Form
(HIPAA 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 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.

Messages

Please call ☐ my home ☐ my work ☐ my cell number:_____

If unable to reach me: ☐ please leave a message

☐ _____

Signed:_____ Date:___/____/_____

Witness:_____ Date:___/____/_____