**Medical Information Release Form**

(HIPAA Release Form)

Last Name: _____ First Name: _____ Birthdate _____

**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 _____

[ ] Other _____

[ ] Other _____

[ ] Information is not to be released to anyone.

The Release of Information will remain in effect until terminated by me in writing.

**Messages**

Please call my [ ] home [ ] work [ ] 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 of day to reach me is between _____ to _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____