MEDICAL INFORMATION ~ HIPAA AUTHORIZATION 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:

[ ] you may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] ____

The best time to reach me (day)____________________between (time)__________

Signed:____ Date: _____/_____/______

Witness:_______________________________________Date: _____/_____/______

[Type here]