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:

 [ ] you may leave a detailed message.

 [ ] please leave a message asking me to return you call.

 [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best time to reach me is [day] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ between [time] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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