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Medical Information Release Form

(HIPAA Release Form)

Name:_____ **Date of Birth:** _____

Release of Information

[ ] I authorize the release of information including but not limited to the diagnosis, treatment, medications list, records of examination, labs and radiology reports, and claims information.

This information may be released to:

[ ] Spouse:_____

[ ] Child:_____

[ ] Other:_____

[ ] **Information is not to be released to anyone but myself.**

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

For Messages, please call: [ ] My home [ ] My work [ ] My cell _____

If unable to reach to 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 Between (time) _____ and _____ .

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Name: (Please Print) _____