Medical Information Release Form
(HIPPA 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 (please include phone number):

[ ] Spouse:_____

[ ] Child(ren):_____

[ ] Parent(s):_____

[ ] 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 [ ] leave a message to return call

Signed:_____ Date_____