DR JOHN P SALERNO

SALERNO WELLNESS

MEDICAL RELEASE (HIPPA) FORM

PREFERRED OFFICE LOCATION

☐ NY ☐ CT

PATIENT'S NAME | DOB

RELEASE OF INFORMATION

☐ I authorize Salerno Wellness to disclose the information including the diagnosis, records, and examination rendered to me to:

NAME OF PERSON | RELATIONSHIP

☐ 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 cell ☐ My work

IIf unable to reach me:

☐ Leave a detailed message

☐ Leave a message asking me to return your call

☐

The best time to reach me is between (time)

This release of information will remain in effect until terminated by me in writing.

PATIENT'S NAME | DATE | WITNESS'S NAME

PATIENT'S SIGNATURE | WITNESS'S SIGNATURE