Acute Care Clinic, Inc
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CHAD A CONATSER, M.D JILL K DENNEY, PA-C JOAN GARDNER, PA-C CHADRICK HULL, PA-C

Medical Information Release Form

(HIPAA Release Form)

Patient Name: _____ Date of Birth: _____/_____/_____

Release of Information

☐ I authorize the use and disclosure of my protected health information, including records and claim information related to my diagnosis and examination. This information may be released to:

☐ Spouse _____Phone #_____

☐ Child(ren) _____Phone #_____

☐ Other _____Phone #_____

☐ 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 (mark one): my home___ my work___ my cell___

Phone # :_____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Other: _____

The best time to reach me:

(day of week) _____ (time of day) _____

Signed: _____ Date:_____/_____/_____

Witness: _____ Date:_____/_____/_____