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 (please name them):

First and Last Name	Relationship to Patient	Best Contact Number

☐ **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 me at my preferred phone number:

Phone Number: ______________________________ [ ] my home [ ] my work [ ] my cell

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] other: ______________________________

____
Patient Signature Date

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Parent or Legal Guardian if Minor Date