

# Saucony Smiles

## 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:

☐ Spouse \_\_\_\_\_

☐ Child(ren) \_\_\_\_\_

☐ 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

☐ please leave a message asking me to return your call

☐ \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_