Medical Information Release Form

(HIPAA Release Form)

Patients Name:_____ Date of Birth:___/___/____

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.**All responsible parties on the account, including insurance cardholders, must be listed below** (**PLEASE PRINT NAMES**):

( ) **Spouse**_____

( ) **Child(ren)**_____

( ) **Parent(s)**_____

( ) **Other**_____

( ) **Information is not to be released to anyone**

The best contact number I can be reached on/at:

( )My home_____

( ) My Work_____

( ) My Cell_____

A detailed message may be left on my voicemail ( ) Yes ( ) No

This ***Release of Information*** will remain in effect until terminated by me in writing.

Patient or Guardian Signature: _____ Date: ___/___/____

Relationship to the patient if a minor: _____

Witness: _____ Date:___/___/____