Medical Information Release For

(HIPAA Release Form)

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:
    - ■ Parent _____
    - ■ Spouse _____
    - ■ Child(ren) _____
    - ■ PCP _____
    - ■ Other Physician _____

- ○ Information is not to be released to anyone.

MESSAGES

Please call:

- ○ Home # _____
- ○ Cell # _____
- ○ Work # _____

If unable to reach me:

- ○ You may leave a detailed message.

The best time to reach me is _____

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

Signed: _____ Date _____