

HIPAA Release Form

Patient Name: _____ Data 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
- do not leave a message

Signature

Date