Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth___/___/___

[ ] 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 _____

[ ] My information is not released to anyone.

Messages

Please call [ ] Home [ ] Work [ ] Cell Number _____

If unable to reach me:

[ ] Please leave a detailed message
[ ] Please leave a message asking me to return your call

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

**** This release of information will remain in effect for 3 years from signature date****

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name _____
Print Name

_____
Signature

Relationship to Individual Patient: _____

YOU HAVE THE RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT