

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 \_\_\_\_\_

Children \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_