HIPAA RELEASE FORM

Patient 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 ____

___ Child(ren) _______________________________________

___ Other____

___ Information is not to be released to anyone

The release of Information will remain in effect until terminated by me in writing.

Messages

Please Call:

__ My home number: _______________________________

__ My work number: _________________________________

__ My cell number: _____________________________

__ Or email: __________________________________

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