

Medical Information Release Form  
(HIPAA Release Form)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release of Information**

I authorize the release of information, including the diagnosis, medical records/reports, examination rendered to me and claims information. This information may be released to:

My email address \_\_\_\_\_

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

\_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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