# Medical Information Release Form (HIPAA Release Form)

## Release of Information

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 _____

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 cell ☐ my work

If unable to reach me:

☐ You may leave a detailed message on my voice mail.

☐ Please leave a message asking me to return your call.

☐ You may text or email me regarding my upcoming appointments.

☐ Other: _____

The best time to reach me is: ☐ 8am-10am ☐ 11am-1pm ☐ 2pm-4pm

_____ _____

Signature of Patient/Authorized Representative Date