**Medical Information Release Form**

**(HIPAA Release Form)**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Release of information

[ ] I authorize the release of information including the diagnosis, records, examination and claims information. This information may be released to:

 [ ] Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Child(ren)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Information is not to be leased 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to reach me by phone:

 [ ] you may leave a detailed message

 [ ] leave a message asking me to return your call

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_