HIPAA Release Form

Patient Name: _____ **Date**: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information

☐ I **DO NOT** authorize the release of information including diagnosis, records; examination rendered to me and claims information

This information may be released to:

☐ Spouse Name _____ Phone Number _____

☐ Child(ren) Name _____ Phone Number _____

☐ Parent Name _____ Phone Number _____

☐ Other Name _____ Phone Number _____

☐ NONE

Messages

Please Call:

☐ My Home Number _____

☐ My Work Number _____

☐ My cell Number _____

If unable to reach me:

☐ You may leave a detailed message (detailed messages can only be left on voicemails that identify patient name)

☐ Please leave a message asking me to return your call

☐ Do not leave a message

_____ _____

Signature Date

This release will expire 12 months after signature date. Release can be terminated prior to 12 months in writing.