MEDICAL INFORMATION RELEASE FORM

HIPAA RELEASE FORM

NAME_____ DATE OF BIRTH_____/_____/_____

RELEASE OF INFORMATION

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

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Parent(s)_____

[ ] Other_____

[ ] INFORMATION IS NOT TO BE RELEASED TO ANYONE.

This release will remain in effect until terminated by me in writing. Initial _____

MESSAGES

[ ] You may reach me at _____/_____ /_____

[ ] YOU MAY LEAVE A DETAILED MSG [ ] LEAVE A MSG ASKING ME TO RETURN YOUR CALL

HIPAA

[ ] A Notice of Privacy Practices has been offered to me or made available should I choose to take one