Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date: _____

Please choose option 1 or 2

1) I authorize the release of information including the diagnosis, records; examination rendered to me and claim information. This information may be release to the following:

☐ _____

☐ _____

☐ _____

OR

2) Information is NOT to be released to anyone. Password_____

This Release of Information will remain on file until replaced by another release form.

Messages

Please Call ☐ my cell _____ ☐ my work _____

If unable to reach me:

☐ you may leave a detailed message
☐ please leave a message asking me to return your call
☐ do not leave a message

The best time to reach me is (days)_____ between (time)_____

Signed: _____Date: _____

Witness: _____ Date: _____