MEDICAL RELEASE FORM (HIPPA RELEASE FORM)

Patient Name: ______________________________ Date of Birth: ____/____/________

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. The information may be released to the following:

- ☐ 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 phone ☐ My work phone ☐ My cell phone

If unable to reach me:

- ☐ Please leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ ______________________________

The best time of day to reach me is (day) ____________________ ☐ Morning ☐ Afternoon

Patient/Guardian Signature: ______________________________ Date: ____/____/________

Witness Signature: ______________________________ Date: ____/____/________

HIPAA Privacy Act

By signing, I state that I have been provided with the HIPAA Privacy Act information in the form of a pamphlet.

Patient Name (Printed): ______________________________ Date: ____/____/________

Signature of Patient or Legal Guardian: ______________________________

If Legal Guardian, Relationship to Patient: ______________________________

Print Name of Legal Guardian: ______________________________