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Medical Information Release (HIPAA Release) Form

Name:____ Date Of Birth:_____/_____/________

Release Of Information

[ ] I authorize the release of information included in the chart notes containing diagnosis, treatment, labs/imaging, examination(s) rendered to me and financial information. This information may be released to:

[ ] Spouse: ____

[ ] Child(ren): ____

[ ] Other(s): ____

[ ] I authorize the release of information stated above EXCEPT for marked section(s): [} diagnosis, [ ] treatment, [ ] labs/imaging, [ ] financial information.

[ ] None of my medical information is to be released to anyone

This **Release Of Information** will remain in effect until terminated by me in writing.

Office Messages:

Please call [ ] My home [ ] My work [ ] My cell phone

This is the best phone number: ______________________________________

If unable to reach me:

[ ] You may leave a detailed message on the above phone

[} Please leave a brief message asking me to return your call

[ ] ____

The best time to reach me is (day of week) ________________between (time)____________________

Signed: ____Date: _____/____/________