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Medical Information Release Form (HIPPA)

Patient Name: _____ DOB: _____

Release of Information

Please initial appropriate section:

( ) I authorize the release of information including but not limited to, diagnosis, records, examination rendered to me and claims information.
This information may be released to:
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____

( ) Information is NOT to be released to anyone.

Patient Notification

Please initial appropriate section:

I would like your office to call:
( )my home ( )my cell ( )my work ( )other: _____

If unable to reach me, you may leave a:
( ) Detailed message including appointment, prescription and or normal result information
( ) Message asking me to return your call only
( ) It is ok to leave a detailed message with named person(s) listed above
( ) Other: _____

Patient Signature: _____ Date: _____