MEDICAL RELEASE FORM

(**HIPPA RELEASE FORM**)

NAME: _____ **DATE OF BIRTH**: _____

RELEASE OF INFORMATION

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

- Spouse: _____
- Child/ren: _____
- Other: _____
- Information is not to release to anymore

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

MESSAGES

In the situation that a message needs to be left, please call:

- My Home Phone: _____
- My Work Phone: _____
- My Cell Phone: _____
- Other: _____

If unable to reach me:

- You may leave a detailed message.
- Please leave a message asking me to return your call.
- Other: _____

The best time to reach me is (day) _____ between (time) _____ and _____

SIGNATURE: _____ DATE: _____