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Medical Information Release Form
(HIPAA Release Form)

Patient's Name: ______________________________ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse ______________________________ Parent 1 ______________________________

Child(ren) ______________________________ Parent 2 ______________________________

School/Other ______________________________ Grandparent ______________________________

______________________________ ______________________________

[ ] 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 ______________ [ ] my work ______________ [ ] my cell number ______________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________

The best time to reach me is (day) ____________ between (time) ________________

Pharmacy

Pharmacy Name ______________________________

Location/Intersection ______________________________

Phone number ______________________________

Signed: ______________________________ Date: ____/____/____

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