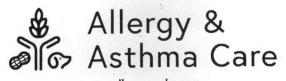
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## Medical Information Release Form (HIPAA Release Form)

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Patient's Name:	_ Date of Birth:/
Release of	<u>Information</u>
[ ] I authorize the release of information includ me and claims information. This information may be	ing the diagnosis, records, examination rendered to e 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 un	
Mes	ssages
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 retu	ırn your call
[ ]	_
The best time to reach me is (day) be	
	rmacy
Pharmacy Name	
Location/Intersection	
Phone number	
Signed: Da	ate:/