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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: ____/____/____