Medical Information Release Form

(HIPAA Release Form)

Name:____ Date of Birth:_____ _____ _____

Release of Information

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

- ☐ Spouse____
- ☐ Child(ren)____
- ☐ Family Dentist & Primary Care Doctor_______________________________________
- ☐ Other____
- ☐ 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

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)_________________

Signed:____ Date:_____/______/______

Witness:____Date:_____/______/______