<u>Medical Information Release Form</u> (HIPAA Release Form)

Name:	Date of Birth:/
	Release of Information
	I authorize the release of information including the diagnosis, records; nation rendered to me and claims information. This information may be released
	[] Spouse
	[] Child(ren)
	[] Other
[]	Information is not to be released to anyone.
This R	elease of Information will remain in effect until terminated by me in writing.
	<u>Messages</u>
Please	call [] my home [] my work [] my cell Number:
If unab	le to reach me:
	[] you may leave a detailed message
	[] please leave a message asking me to return your call
	[]
The be	est time to reach me is (day) between (time)
Signed	l: Date:/
Witnes	ss: Date: / /