

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 results, medication dose changes, and claims information.

This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____

- Information is not to be released to anyone other than me.

Messages

Please call my home phone is _____ my cell phone is _____

If unable to reach me:

- You may leave a detailed message

OR

- Please leave a message asking me to return your call

- Do not leave messages on my phone mailbox.

The best time to reach me is (day of week) _____ between (time) _____

E-mail Messages

- Use my e-mail address to send messages for me to contact the nurse for information **OR**
- Use my e-mail to leave detailed messages and information.

Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____