Medical Information Release Form

(HIPAA Release Form)

Full Name:	Date of Birth:

Release of Information

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

[ ] Spouse_____
[ ] Child(ren)_____
[ ] 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 number_____
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*)_____

****Furthermore, I have been offered the opportunity to review, read and understand the PPT Notice of Privacy Practice.**

Patient Signature:	Date:
Witness:	Date: