HIPAA RELEASE FORM

HIPAA Authorization Release of Information

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Release of Information

( ) I authorize the release of information including the diagnosis, examination records, claims information, and billing information. This information may be released to:

( ) Spouse _____ Phone #:_____

( ) Children _____ Phone #:_____

( ) Parent(s) _____ Phone #:_____

( ) Other _____ Phone #:_____

( ) Information is not to be released to anyone.

This Release **of Information** will remain in effect until terminated by me in writing.

Phone 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

Signed: _____**Date:** _____ / _____ / _____