Medical Information Release Form - HIPAA

Name of patient: _____ Date of Birth: _____/____/_____

Release of Information

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

( ) Myself

( ) My Spouse _____
(their name)

( ) My Child(ren)_____
(their name/s)

( ) My Primary Care Physician_____
(their name)

( ) Other_____
(their name)

( ) Information is not to be released to anyone.

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

My signature: _____

Today's date: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing the form: _____

Relationship to patient: _____

Signature of person completing this form: _____

Date signed: _____