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Medical Information release form
(HIPAA release form)

*Date:*_____.

*Patient Name:*_____ *Date of birth:*_____.

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

- *Spouse*_____ *Phone #*_____.
- *Child(Ren)*_____ *Phone #*_____.
- ._____ *Phone #*_____.
- *Other*_____ *Phone #*_____.

*Signed*_____ *Date:*_____.

*Witness:*_____ *Date:*_____.