HIPAA Release Form

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

Release of Information:

I _____ authorize the release of information including appointment dates and times, diagnosis, records; examination rendered to me and claims information:

This information may be released to

- ☐ Spouse_____
- ☐ Child(ren)_____
- ☐ Other_____
- ☐ Please do not release information to anyone other than my Primary Care Physician and/or Referring Physician.

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: ____/____/____