Medical Information (HIPAA) Release Form

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

Release of Information

[ ] I authorize the release/sharing of information, including medical and financial records, *to the following*:

Name:______________________ Relation:_____________ Phone:_______________

Name:______________________ Relation:_____________ Phone:_______________

[ ] I DO NOT authorize my information to be released to anyone.

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

Permission to Contact

[ ] *OK To*: leave a detailed phone message ***OR*** [ ] Please leave a message asking me to return your call for details

[ ] *OK To*: text my cell

[ ] *OK To*: email me

[ ] *OK To*: Send information regarding special events or new products

Signed: ______________________________________ Date: ____/____/_____

Witness:______________________________________ Date: ___/____/______