Medical / Dental Information Release Form
HIPAA Release Form

Patient Name: _____ Date of Birth: _____

Release of Information

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

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

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

Messages

If unable to reach me on [ ] My home number [ ] My cellphone :

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to call back.

[ ] _____

Patient Signature: _____ Date:_____