Medical Information Release Form

(HIPAA Release Form)

Patient Name:___________________________________ Date of Birth:___/___/____

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. ***All responsible parties on the account, including insurance cardholders, must be listed below (PLEASE PRINT NAMES):***

( ) **Spouse____**

( ) **Child(ren)____**

( ) **Parent(s)____**

( ) **Other____**

( ) **Information is not to be released to anyone**

The best contact number I can be reached on/at:

____

A detailed message may be left on my voicemail ( ) Yes ( ) No

I understand by signing this form in the event of a medical emergency, a copy of my medical record will be given to EMS first responders and/or emergency room staff to aid in providing emergency treatment.

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

Patient or Guardian Signature: _____________________________________ Date: ___/___/____

Relationship to the patient if a minor: _______________________________

Witness: _______________________________________ Date:___/___/____