MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name_____________________ Date of Birth____________

Release of Information

I authorize the release of information, including the diagnosis and records, examination rendered to me and/or my child and claims information. This information may be released to:

__ Spouse____
__Child(ren)____
__General Dentist___________________________________
__ Medical Doctor___________________________________
__Other____
__Information is not to be released to anyone.

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

Messages

Please call my __house ___work __Cell number________________
If unable to reach me:
__You may leave a detailed message
__Please leave a message asking me to return your call
The best time to reach me is (day) _____________ between (time)_______________

Signed______________________________ Date_______________

Witness_____________________________ Date_______________