Medical Information Release Form (HIPAA Release Form)

Patient's name: ________________________________Date of Birth: ____/____/_____

[ ] I authorize information to be released to:

( ) **My Spouse/Significant other**

Name and phone #:____

( ) **Caregivers**

Name and phone #:____

( ) **Other (ex. Relatives, step parent, emergency contact)**

Name, Relationship, Phone #:____

[ ] Information is **NOT** to be released to anyone other than another medical provider.

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

This Release of Information **will remain in effect until terminated by patient, guardian, or POA**

Signature of **Patient** or **Guardian**: ______________________________Date: __________

Printed Name of **Patient**: ___________________________________Date: ___________