Personal Health Information Release Form

(HIPAA Release Form)

Name:_____Date of Birth_____/_____/_____

Release of Information

___I authorize the release of any and all information including the diagnosis, financial and dental 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

Please call ___my home ___my work ___my cell number_____

If unable to reach me:

___please leave a detailed message

___please leave a message asking me to return your call

___ _____

The best time to reach me is (day)_____between (time)_____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.

Signed:_____Date____/____/____