Medical Information Release Form
(HIPPA Release Form)

Name: _____Date of Birth: ___/___/___

Release of Information

[ ] I authorize the release of information including the 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.

Signature: _____Date: _____