Medical Information Release Form (HIPAA 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.

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

Prescription Release

I, ________________________, agree to release all prescriptions history to Dalewood Medical Center for the use of my healthcare.

Printed Name: _______________________________ Date: ____________________

Signature: ___________________________________

Messages

Please call:
☐ My home ☐ My work ☐ My mobile 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: ___________________________