



Medical Information Release Form
(HIPPA Release Form)

Patient Name: _____ Birthdate: _____

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) _____

Parent(s) _____

Other _____

Information is NOT TO BE RELEASED to anyone.

Patient or Legal Guardian Signature

Date

Witness Signature

Date