MEDICAL INFORMATION RELEASE FORM

Patient Name: ____ DOB: ____________________

Street Address: ____

City, State, Zip: ____ Phone: ____________________

Release of Medical 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.

Messages

Please call:

- ☐ My home ______________________
- ☐ My work ______________________
- ☐ My cell ______________________

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave a message asking me to return your call.
- ☐ ______________________

____ Date ______________

Signed

____ Date ______________

Witness