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.

Snake River DERMATOLOGY

Messages

Please call   [ ] my home   [ ] my work   [ ] my cell number ________________ If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] other _______________________________________

The best time to reach me is (day)__________________________ between (time)__________________

Signed: ____ Date: ___________________________

Witness: ____ Date: ___________________________