Medical Information Release Form

Name: _____ **Date of Birth:** _____

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: [ ] Home [ ] Work [ ] Cell:_____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____