Medical Information 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_____
    - Self _____
- 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 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:_____/_____/_____