



## Medical Information Release Form

Patient 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.

### 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

☐ Other \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ time \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_