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.

[ ] Spouse ____

[ ] Children ____

[ ] 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 phone number: ___________________

If unable to reach me:

[ ] You may leave a detailed message

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

[ ] ____

The best time to reach me is (day) _____________________ between (time) _________________

Signed:____ Date: ____/____/_____

Witness:____ Date: ___/____/______