MEDICAL INFORMATION RELEASE FORM

Name: _____ Date of Birth:_____

RE: Release of Information:

I hereby authorize the release of information including the diagnosis, records, examination rendered to me and claims information to: (check box)

☐ Spouse:_____

☐ Child(ren):_____

☐ Employer:_____

☐ 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 number: ☐ home_____ ☐work_____ ☐mobile_____

If unable to reach me:

☐ leave a detailed message

☐ leave a message asking me to return your call

☐ (specify)_____

The best time to reach is (day)_____ between (time)_____and (time)_____

Signed:_____ Date:_____

Witness:_____ Date:_____