Medical Information Release Form
&
HIPAA Release Form

Name of Patient: ____ **Date of Birth**:______/______/_______

How would you like our office to contact you regarding medical results and/or other medical and billing related issues? This information will remain in effect until terminated by the patient in writing.

	_________ Home Phone	_____ Work Phone
Initial all that apply	_________ Mail	_____ Cell Phone
	_________ Patient Portal	

I authorize the release of all private medical information and results including diagnoses, records, and claims information from the examination(s) rendered to me. This release of information will remain in effect until terminated by me in writing for the following people(s):

	NAME	Relationship
1)	____________________________________	____________________________________
2)	____________________________________	____________________________________
3)	____________________________________	____________________________________
4)	____________________________________	____________________________________
5)	____________________________________	____________________________________

Please provide us with a current copy of your Power of Attorney, Living will or guardianship papers (should you have any). These forms will be added to our records.

Patient Signature:____ **Date:**___________

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