Medical Information Release Form

(HIPAA Release Form)

Name:_____ **Date of Birth:**__/__/___

Release of Information

[ ] I authorize the release of information including diagnosis, records, examination, 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: [ ] home_____ [ ] work _____ [ ] 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)_____between (time)_____

Signed: _____ Date: __/__/____

Witness: _____ Date: __/__/____

Transitions Chronic Care participates in the CORHIO Health Information Exchange Program