Electronic/Technology Medical Information Communication Release Form (HIPAA Release Form)

Patient's Name: _____ Date of Birth: ____/____/____ Patient's Name: _____ Date of Birth:___/ ____/____

Parent's Name: _____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

☐ - Self _____

☐ - Child(ren) _____

☐ - Other _____

☐ - Information is not to be released to anyone other than me.

BY MEANS OF:

Messages

Please call ☐ my home phone is _____ ☐ my cell phone is _____

If unable to reach me:

☐ - You may leave a detailed message

OR

☐ - Please leave a message asking me to return your call

☐ - Do not leave messages on my phone mailbox.

The best time to reach me is (day of week)_____ between (time)_____

E-mail Messages

☐ - Use my e-mail address to send messages for me to contact the front desk for information **OR**
☐ - Use my e-mail to leave detailed messages and information per **MY** request.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature:_____ Date: ____/____/____