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# Medical Information Release Form

(HIPAA 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 to:

Spouse: \_\_\_\_\_

Child(ren) : \_\_\_\_\_

Health Care Providers: \_\_\_\_\_

Other : \_\_\_\_\_

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_