HIPAA Release of Information

Patient Name: _____ *DOB*: _____

1. The following people can be given information concerning my health:

   Spouse: _____ Phone: _____

   Parent/Guardian: _____ Phone:_____

   Other:_____ Phone:_____

   Other: _____ Phone:_____

2. I may be contacted by mail with issues concerning my health: Yes No

3. You may leave a message at my home, cell voice mail concerning: (*Please circle all that apply*)

- Appointment time
- Medication information
- Procedures/Referrals
- Test/Lab & X-Ray Results
- Pharmacy Call Ins.

I understand that the above information will be placed in my file and will be effective such a time I deem as necessary to revoke. At time of revocation, I understand that I will be expected to complete a new HIPAA release of information form. I further understand that said revocation must be in writing.

_____ _____
Signature of patient/parent/guardian Date

_____ DOB: _____
Printed Name of Patient

_____ _____
Witness signature/office use only Date