MEDICAL INFORMATION RELEASE FORM

This form is mandated by HIPPA, and must be completed before we can release any information about you to your family or other designated recipients.

RELEASE OF INFORMATION:

I authorize the release of any and all information contained in my record. This information may be released to the following idividuals:

[ ] Spouse: please name ____

[ ] Child(ren) please name____

[ ] Other please name____

[ ] Please do not release my information to anyone.

By HIPPA law, we cannot release your information to anyone other than those you've listed above.

This Release of information will remain in effect until terminated by you in writing.

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Signature Date