

Medical Information Release Form  
HIPAA Release Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release Information To**

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

Child(ren) Name(s): \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

Other Name(s): \_\_\_\_\_

Information is not to be release to anyone.

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_