DOYLESTOWN DERMATOLOGY

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: _____

[ ] Children: _____

[ ] Other: _____

[ ] Information is not to be released to anyone.

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

MESSAGES

Please call [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

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

Signature: _____ Date: __/__/__

Witness: _____ Date: __/__/__