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Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

This Disclosure authorizes my medical information to be release to the following individuals:

[ ] Parent/Partner: _____
[ ] Child(ren): _____
[ ] Other: _____
[ ] My Medical Information is **NOT** to be released to anyone.

Type of Information to be used or disclosed is as follows (check all that apply):

[ ] Attendance and Scheduling
[ ] Psychiatric Exam and/or Treatment Reports
[ ] Account and Billables
[ ] Discharge Summary and Instructions
[ ] Lab Results
[ ] Verbal and/or Written Communication
[ ] Other: _____
[ ] **ALL INFORMATION LISTED ABOVE.**

This **Release of Information** will remain in effect until terminated by me in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that my record may contain information in reference to drug and/or alcohol abuse, sexually transmitted diseases, Hepatitis B, Hepatitis C, HIV/AIDS, or other sensitive information, I agree to its release. I am voluntarily allowing the release of the above information. No threat or other coercive measures have induced me to sign this consent form.

_____ _____
Patient/ Guardian (if under 14 years old) Signature Date

_____ _____
Witness's Signature Date