

Patient HIPAA Release Form

We are unable to discuss your treatment with any anyone unless you give us written anyone unless you give us written permission.

I authorize the release the of information to the person(s) below:

() Spouse Name: _____

() Child(ren) Name(s):

() Information is not to be released to anyone.

Messages

Please call my () home () work () cell
Number _____

If unable to reach me:

() You may leave a detatiled message

() Please leave a message asking me to return your call

() Other _____

A copy of this policy is avaiable to you at your request.

Patient Name: _____

Signed: _____

Date: _____