DESIGNATED INDIVIDUALS RELEASE FORM

(HIPAA RELEASE FORM)

PATIENT 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:_____________________________________

_____ Child (ren):__________________________________

____

_____ Other:______________________________________

_____ Information is NOT to be released to anyone other than me.

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

MESSAGES

Please call me: ______at home ______ at work _______ on my cell #:___________________________

If unable to reach me:

_____ You may leave a detailed message on the recording

_____ Leave only a name and number and ask me to return the call

I understand that I may change this information at any time by asking to complete a new Designated Individuals Release Form.

____ DATE:__________________________

Signature of patient (if over 18) or patient's parent or legal guardian signature

If signed by a parent/ legal guardian, please print name of signature above:____________________________________