HIPAA RELEASE FORM

Patient Name: _____ Date of Birth: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family or other relations regarding your medical treatment and patient financial information. Each individual listed we will be able to release any information to them needed in regards to your medical history.

Please print the names, relationship and telephone numbers you would like to authorize the release of your private heath care information and account balances(including a Spouse or Significant Other).

_____ _____ _____

Name Relationship Phone #

_____ _____ _____

Name Relationship Phone #

_____ _____ _____

Name Relationship Phone #

_____ _____

_____

Name Relationship Phone #

_____ _____

Patient Signature Date