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MEDICAL INFORMATION RELEASE FORM

Name: ____ DOB: ____________________

( ) I authorize the release of information including diagnosis, records, examinations rendered to me and claims information. This information may be released to:

( ) Spouse/Significant Other ____
( ) Child ____
( ) Other ____
( ) Other ____
( ) Other ____
( ) Information is not to be released to anyone.

I further authorize the practice to communicate with my other healthcare professionals and providers where the practice deems it advisable or necessary in providing care to me.

This release of information will be in effect until terminated in writing.

____ _______________________
Signature of patient/guardian/legal representative Signature date

____ _______________________
Signature of witness Signature date