SOMA
MEDICAL CENTER, P.A.

Medical Information Release Form (HIPPA Release Form)

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.

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

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach is (day) _____ between (time)_____

Signed:_____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____