Medical Information Release Form

(HIPAA Release Form)

Full Name:	Date of Birth:

Release of Information

[ ] I authorize the release of information including the diagnosis, records, and 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.

Patient Contact Information and Messaging Preferences

Email Address_____

Cell Phone number_____ Home/Alt Ph # _____

It is okay to contact me by (select all that apply):
[ ] Text [ ] Email [ ] Personal Phone Call/Voicemail

Do you wish to receive automated text message appointment reminders? [ ] Yes [ ] No
Do you wish to receive automated email appointment reminders? [ ] Yes [ ] No

If unable to reach me by phone:
[ ] you may leave a detailed message [ ] please leave a message asking me to return your call

[ ] (other)_____

Emergency Contact: *Name* _____ *Ph#* _____

Relationship: _____

****Furthermore, I have been offered the opportunity to review, read and understand the PPT Notice of Privacy Practice.**

Patient Signature:	Date:
Witness:	Date: