Medical Information Release Form
(HIPAA Release Form)

Name:…… DOB:……

Release 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

Please call [] My Home [] My Work [] My Cell:……(……)……
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 me is (*Day*)…….. Between (*Time*)…….

⊗ **…… Date: ___ / ___ /_____**
Patient, Parent, Legal Guardian or Authorized Representative Signature.

Patient Print name…….. DOB:……..

****IMPORTANT MESSAGE TO OUR PATIENTS****

1. **IF YOU ARE SEEN BY OUR MEDICAL PROVIDER TODAY FOR YOUR VISIT, YOU WILL BE FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED <u>EVEN IF YOU ARE REFERRED TO THE EMERGENCY ROOM FOR FURTHER EVALUATION</u>. THERE WILL BE NO REFUND OF PAYMENT AND YOUR INSURANCE (IF APPLICABLE) WILL BE BILLED FOR YOUR VISIT TODAY.**
2. **WE ALSO WANT TO MAKE YOU AWARE PRIOR TO YOUR VISIT TODAY; <u>OUR PROVIDERS ARE UNABLE TO ADMINISTOR PRESCRIPTIONS FOR NARCOTICS.</u>** *IF YOU FEEL YOUR VISIT TODAY MAY REQUIRE A NARCOTIC BEING PRESCRIBED, WE ARE UN ABLE TO PROVIDE YOU WITH TYPE OF MEDICATION.*

I have read the above statements and agree to the terms prior to my visit

⊗ **…….. Date:……**
Patient, Parent, Legal Guardian or Authorized Representative Signature.

<u>Please Review and Provide Signature</u>

CONSENT FOR EVALUATION OR TREATMENT
The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

⊗ **…… Date:……**
Patient, Parent, Legal Guardian or Authorized Representative Signature.

Witness signature: …….. Date:……..