HIPAA CONSENT FORM

Please tell us with whom we are allowed to discuss and/or disclose your personal health information.

Please circle all that apply:

myself only spouse parents sibling(s)

adult children(18+) personal representative Employer

Please print name(s) of above:

_____

_____

Messages

Please call [ ] my home [ ] my work [ ] my cell (____)_____

If unable to reach me (check all that apply):

[ ] you may leave a message

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

The best time to reach me is:

(day) _____ between (time) _____

My signature below authorizes the release of medical information to any specialists I may be referred to and to process insurance claims/applications, prescriptions, and lab work.

Patient/Responsible Party Name _____

Patient/Respnsible Party Signature_____ Date_____

This ***release of information*** will remain in effect until terminated by me in writing.
