Pediatric Partners
Where care grows.

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HIPAA Medical information Release Form – For patients 18 years and older

_____

Patient name ***Date of Birth***

Release of Information:

_____ *I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:*

	Name	***Relationship***	***Phone / cell number***
1.	_____		
2.	_____		
3.	_____		

_____ *I do not authorize the release of information to anyone.*

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

Messages:

Please call me at _____

If unable to reach me:

_____You may leave me a detailed message

_____Leave me a message asking me to return your call

Patient signature:_____ Date_____