University Otolaryngology

MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form)

Patient Name:_____Patient DOB_____

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 phone

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)_____

Signed:_____ Date:_____

Witness:_____ Date:_____

If applicable, Legal Representatives Sign Below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g. Power of Attorney, Guardianship papers, DCYF documents, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative:_____

Signature of Legal Representative:_____

Name of Witness:_____

Signature of Witness:_____

Date:_____