Medical Information Release Form

Name: ____ DOB _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and the claims information. The information may be released to :

[ ] Spouse/Partner ____

[ ] Child(ren) ____

[ ] Other ____

[ ] Information is not to be released to anyone

Signed: ____ Date _____/_____/_____

This Release of Information for will remain in effect until the form is updated or until terminated by me.