**MILTON MEDICAL GROUP**

**Medical Information Release Form**

**(HIPAA Release Form)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Date of Birth** |  |

**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 | Name: |
| [ ]  | Child(ren) | Name(s): |
| [ ]  | Other | Name(s): |
| [ ]  | Information **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 Number(s):

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)\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |
| Witness: |  | Date: |  |