# 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: | |