3750 Dacoro Lane Suite #140
Castle Rock, CO 80109
303-660-6005 Phone
303-660-6095 Fax

Medical Information Release Form (HIPAA Release Form)

Print Patient 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_____
[ ] 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 Number:_____
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*)_____

I acknowledge that I have read this office's HIPAA form, which is available at the front desk.

X _____ Date: ____/____/_____
Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)