Freed Plastic Surgery

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

Name: _____ D.O.B. _____

RELEASE INFORMATION

☐ I authorize the release of information including the diagnosis, record; 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.

BEST NUMBER TO LEAVE A PHONE MESSAGE ON

☐ Home _____

☐ Work _____

☐ Cell/Mobile _____

If unable to reach me:

☐ Your office may leave a detailed message

☐ Your office may leave a message asking me to return the call

☐ _____

This release of information will remain in effect until terminated by me in writing.

SIGNED: _____ DATE: _____

WITNESS: _____ DATE: _____