CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN #_____

Medical Information Release Form
(HIPAA Release Form)

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 number _____

[ ] my work number _____

[ ] 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)_____

Signature of Patient (or Guardian): _____ Date: ____/____/_____
Signature of Witness:_____ Date: ___/____/_____