WALLACE FOOT & ANKLE CENTER

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_____
[ ] 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 (*day*) _____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____