PEAK HEALTH
FAMILY MEDICINE

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ DOB _____

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_____ Phone:_____

[ ] Child(ren)_____Phone:_____

[ ] Parent_____Phone:_____

[ ] Parent_____Phone:_____

[ ] Other_____Phone:_____

[ ] Do NOT release information to anyone outside of healthcare.

I UNDERSTAND THAT THIS RELEASE WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME IN WRITING.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] Please leave a detailed message on my voicemail.
[ ] Do not leave a voicemail. Please leave a message asking me to return your call.
[ ] _____
It is best to reach me: (day)_____ between (time)_____

Is it okay to email or send a text message as a reminder for any future appointments?
Yes:____ Email: _____
No: ____

Signature: _____ Date: _____