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MEDICAL INFORMATION RELEASE FORM

HIPAA RELEASE FORM

RELEASE OF INFORMATION-CONFIDENTIAL

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) ____

( ) ____

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ( ) Home ( ) Work ( ) Cell Phone

( ) You may leave a detailed message

( ) Please leave me a message asking me to return your call

Signature ________________________________ Date ________________________________