New Hope
Prosthetics & Orthotics

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: _____

Children: _____

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: *home*: _____ *work*: _____ *cell number*: _____

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

Other: _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____