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HIPAA RELEASE FORM

Patient Name: _____ Medical Record #: _____

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #

Patient Signature

Date