ADVANCED NEUROSCIENCES INSTITUTE

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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.

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 is (day)_____________________ between (time)______________________

Signed: ____ **Date of Birth:** ____/___/____

Witness: ____ **Date of Birth:** ____/___/____