NY LONGEVITY

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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 diagnoses, records, examination results medications dose changes, and claims information.

This information may be released to:

- Spouse: _____
- Child(ren): _____
- Other: _____
- *Information is not to be released to anyone other than me.*

Messages

Please call - my home phone _____ or my cell phone_____.

If unable to reach me:

- *You may leave a detailed message* ***OR***
- *Please leave a message asking me to return your call*
- *Do not leave messages*

The best time to reach me is (day of week) _____between (time) _____.

This Release of Information will remain in effect until terminated by me in writing. The release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: