Aspire
Physical Therapy Sports Medicine

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

NAME:_____ DATE OF BIRTH:_____

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, any and all records, and claim 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.

MESSAGES

Please call [ ] my home _____ [ ] my work _____

[ ] my cell_____

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)_____(time)_____

Signed:_____Date:_____

Witness:_____Date:_____