DSCS Medical Information Release Form

(HIPPA Release Form)

Patient Name_____ DOB_____

Release of Information

[ ] I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to the following:

- **[ ] 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 [ ] CELL [ ] WORK

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)_____

Signature _____ Date _____