White Mountain Eye Institute HIPPA Release Form

Medical Information Release Form - HIPPA

Patient Full Name: ______________________________ Date of Birth: ____________________

Release of Information

- ☐ I authorize the release of information including the diagnosis, records of 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.

Messages

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
- ☐ Other: ____

For appointment reminders, please:

☐ Call ______________________ and/or ☐ Text ________________________

____ _________________________

Patient or Legal Representative Signature Date