7000 Parkwood Blvd, Ste B200
Frisco, TX 75034

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Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ **Date of Birth** ____/______/_______

- 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.

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
- ____

Signed:____ Date ______________