Family Practice Assocs. of Exton & Marshallton

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

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

O Spouse_____

O Child(ren)_____

O Other_____

O 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

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____