PRINT

SUBMIT

Schwartz
Therapy + Wellness, P.C.
small steps every day

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

□ I authorize the release of information including the diagnosis and/or records of my psychotherapy session/s 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: _____

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

Signed: _____ Date: _____

Therapist Sign Off: _____ Date: _____