URGENT CARE
OF OCONEE

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ Date of Birth: _____

Release of Information

[ ] 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 in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my mobile number

If unable to reach me:

[ ] you may leave a detailed voice mail message
[ ] please leave a message asking me to return your call
[ ] other: _____

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

Patient (or Guardian) Signature: _____ Date: _____ Print

Patient Name:_____

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