Patient Information Release Form

In accordance with new Federal and HIPPA (Healt Insurance Portability and Accountability Act) regulations, any medical information pertaining to you will only be disclosed to the persons(s) indicated below. If they are NOT listed below, no information will be discosed at any time. Thank You for cooperation.

First name	Last name	Relationship

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☐ I do not with to have any of my health-related information released to anyone other than myself.

Any changes of patient release information must be in writing ONLY.

Patient's Signature

☐ I agree with the above conditions

Date