Waterfalls
Longevity Center PLLC

HIPAA Release of Information Form

Patient Name: _____ DOB: _____

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 terminates 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

( ) Do not leave a message

_____ _____

SIGNATURE DATE