HIPAA RELEASE OF INFORMATION

The following people can be given information concerning my health care and treatment:

Spouse/significant other: Name: _____

Other specified person: Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

I accept information by mail regarding issues concerning my health? Y N

The following information may be left by voice mail or on answering machine:

Appointment date/time	Y	N
Medication information	Y	N
Procedure information	Y	N
Referral information	Y	N

_____
Printed Name

_____ _____
Signature Date

_____ _____
Witness Date