Medical Information Release Form

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 _____
Phone#_____

[ ] Child(ren)
_____Phone#_____

[ ]
Other_____Phone#_____

[ ] 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

House of Wellness

[ ] _____

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

Signed: _____. Date ____/_____/_____

Witness: _____. Date ____/_____/_____