

# HIPAA Disclosure Form

Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Listed Address: \_\_\_\_\_

Preferred Correspondence Address: \_\_\_\_\_

Listed Phone No. \_\_\_\_\_ Preferred Phone No. \_\_\_\_\_

Listed Email Address: \_\_\_\_\_

Preferred Email Address: \_\_\_\_\_

Would you like our correspondence with you to be marked "Confidential"?  Yes  No

May we identify ourselves over the phone?  Yes  No      May we leave messages?  Yes  No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_