Youens & Duchicela Clinic
FAMILY MEDICINE | BOARD CERTIFIED

Medical Information Release Form

(HIPAA 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 _____
  - Child(ren) _____
  - Other _____
- ○ I do **not** authorize any information to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

Home: _____ Work: _____ Cell: _____

If unable to reach me, you may leave a detailed message. Please leave a message asking me to return yoru call. The best time to reach me is (date) _____ between (time)_____.

Signature: _____ Date: _____