RIVER CITY ALLERGY & MEDICAL

MEDICAL INFORMATION RELEASE

HIPPA

NAME_____ DOB_____

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS, EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

NAME RELATIONSHIP

_____

_____

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MESSAGE PREFERENCES

PLEASE CALL ___MY HOME ___MY WORK ___MY CELL_____

IF UNABLE TO REACH ME:

__YOU MAY LEAVE A MESSAGE CONTAINING MEDICAL INFORMATION

__PLEASE LEAVE A MESSAGE ASKING ME TO RETURN YOUR CALL

__OTHER (SPECIFY)_____

THE BEST TIME TO REACH ME IS (DAY)_____ (TIME)_____

THIS RELEASE OF INFORMATION CONSENT WILL REMAIN IN EFFECT UNTIL

TERMINATED BY ME IN WRITING.

SIGNED_____ DATE_____

WITNESS_____DATE_____