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**Protected Health Information Release Form**  
**(HIPAA Release Form)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

Information is not to be released to anyone.

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): \_\_\_\_\_

Parent: \_\_\_\_\_

Other: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_