



# Medical Information Release Form

## HIPAA Release Form

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guarantor Name: \_\_\_\_\_

### RELEASE OF INFORMATION

I authorize GO Sports Therapy to release my information including the diagnosis, medical records, billing records; rendered to me. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

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 cell \_\_\_\_\_  my work \_\_\_\_\_

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

\_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_