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: _____

☐ Information is not to be released to anyone.

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

Prescription Release

I, _____, agree to release all prescriptions history to Virginia Gateway Urgent Care Center for the use of my healthcare.

Printed Name: _____ Date: _____

Signature: _____

Messages

Please call:
☐ My home
☐ My work
☐ My mobile number: _____

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: _____

Witness: _____ Date: _____