BUXMONT PULMONARY & SLEEP MEDICINE

Medical Information release Form (HIPPA Release Form)

Name: _____ DOB: ____/____/_____

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.

SIGNATURE: _____ Date: _____

Witness: _____ Date: _____