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.

The information may be released to:

☐ Spouse _____

☐ Children_____

☐ Parent_____

☐ Other_____

☐ Information is NOT to be released to anyone.

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

I further agree that the practice may disclose health information to me in the following manner:

☐ Home #_____ ☐ Cell #_____ ☐ Other_____

If unable to reach me:

☐ You may leave a detailed message.

☐ Please leave a message asking me to return your call.

I,_____ (Patient/Parent of minor), acknowledge that I have received a copy of Robert P. Rabinowitz, DO, PA's notice regarding Privacy of Personal Health Information.

Signed _____ Date:_____