the thrivegroup
WHOLE SELF WHOLE FAMILY

1-973-602-7744 thethrivegroup.co

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.

Messages

Please call: ○ My home ○ My work ○ My cell 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: ______________