sheperd
INTEGRATIVE DERMATOLOGY

HIPAA Release Form

Patient Name:_____ Date of Birth:_____

I,_____ (patient name) authorize the release of my information to include the following:

_____ Diagnosis

_____ Records

_____ Examination and Procedures Rendered

_____ Claims Information and Billing Records

_____ Appointment and Scheduling Information

_____ Do Not Release Any Information to Anyone

This information may be released to: _____

Relationship to the Patient:_____

This release of information will remain in effect until terminated by me in writing.

Signature_____

Date_____