HYATT HEALTH
HIPPA Release Form

Patient Name:_____ Date of Birth:_____

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse:_____ Phone Number:_____

Child(ren):_____ Phone Number:_____

_____ Phone Number:_____

Other:_____ Phone Number:_____

I do not want my information to be released to anyone. (Initial)_____

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

Messages

Please call ( ) Home ( ) Work ( ) Cell at Phone Number:_____

If unable to reach me:

( ) You may leave a detailed message.

( ) Please leave a message asking me to return your call.

( ) You may leave a text message on my cell phone.

The best time to reach me is between the hours of _____a.m. and _____p.m.

Signature:_____ Date:_____

Notice to client: Hyatt Health or a provider agency as a receiver of this information, will protect your personal information in accordance with the federal and state privacy regulations. If you authorize the release of your health information to other parties, it may no longer be protected by privacy regulations.