Platte Valley Internal Medicine and Pulmonary
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MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Patient Name: _____ DOB: _____

Release Of Information

☐ **I authorize Platte Valley Internal Medicine & Pulmonary may release the following specified information regarding me:**

☐ Test Results (including, lab, x-ray, any diagnostic testing) ☐ Billing Information ☐ Appointments

☐ Prescriptions (requesting etc.) ☐ Other: _____

To the following:

☐ Spouse: _____

☐ Children: _____

☐ Other: _____

☐ **Information is to *NOT* be released to anyone.**

Messages

☐ **I authorize Platte Valley Internal Medicine & Pulmonary to call (PLEASE INDICATE PREFERENCE):**

Home _____ Cell _____ Work _____

If unable to reach me:

☐ You may leave a detailed message.

☐ **DO NOT** leave a detailed message.

☐ Other: _____

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

Patient Signature: _____ Date: _____