



Medical Information Release Form (HIPAA Release Form)

I understand that Articularis Healthcare Group, Inc. maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

Check if okay to leave detailed health information on voicemail

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

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____