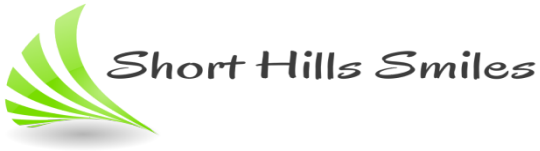

MEDICAL INFORMATION RELEASE FORM

(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.

Signed: _____ Date:___/____/____

Witness:_____ Date:___/____/____