



HIPAA Contact Release Form

Dear Patient,

In order to help us stay within the guidelines of **HIPAA**, please list below any person/persons that you authorize us to disclose information to regarding your Protected Health Information, including billing information. **(You do not need to list any of your doctors.)**

Name	Relationship	Phone
1. _____	_____	_____ Home/Cell
2. _____	_____	_____ Home/Cell
3. _____	_____	_____ Home/Cell
4. _____	_____	_____ Home/Cell

Do we have your permission to leave information on your **answering machine** when you are not at home?

Yes _____ **No** _____

Patient's Name (Please Print)

Date of Birth

Patient's (or Guardian's) Signature

Date