Medical Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release Information

I authorize the release of information including the diagnosis, records; examination rendered for medical treatment or consultation for the individual named above. This information may be released to:

Spouse _____

Other __Youth Leader _____

Other _____

Effective Period

This authorization for release of information covers the period of healthcare from:

_____ to _____

1. I understand this will include information relating to AIDS or infection with HIV, psychiatric care, and treatment for alcohol and/or drug abuse.

2. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization.

3. I understand that these records are subject to re-disclosure and are no longer protected once released.

4. I understand that treatment, payment or enrollment cannot be conditioned on signing this authorization.

5. The facility, its employees, officers, and attending physician are hereby released from any legal responsibility or liability for the release of this above information to the extent indicated and authorized herein:

Signed: _____ Date: _____
(Parent or Guardian)

Print Name: _____ Date: _____