HIPAA Release Form
Medical Information Release

Patient Name: _____ Date of Birth: _____

☐ I authorize Elite Wellness and Anti-Aging to release information including examination rendered to me, diagnosis, records, and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released: _____

Please contact me at the following number(s):

☐ home
☐ work
☐ cell phone

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking for a return call

Permission for release of information will remain in effect until terminated in writing.

Patient/Guardian Signature: _____ Date: _____

Relationship if not the patient: _____