Medical Information Release Form

(HIPAA Release Form)

Name: _____

Date of Birth: _____/____/_____

Release of Information

I, [ ], authorize the release of information including my diagnosis and medical records to:

PAY IT FORWARD NETWORKING.

or

[ ] My information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Guardian (if child is under 18) :_____ Date: ___/____/__

Print Guardian Name: _____