ELPIS
HEALTHCARE

HIPPA RELEASE FORM

Privacy regulations require us to have a release form signed by our patients so we may speak with family members, friends, and other relations regarding medical treatment and financial information. Each person you wish to have as an approved party to receive your medical or financial information and records on file must be listed individually by name (including a spouse or significant other).

Please print your name, relationship, and telephone number for each person when you authorize the release of your private health care information and account balances.

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

This authorization will expire on ____ / ____ / _____ (please fill out the date if it is less than one year). Thank you!

Patient Name: _____ Patient Signature: _____ Date: _____