ADVANCED AESTHETICS

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information, including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

☐ Information is not to be released to anyone.

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

Signed: _____ Date: _____

Witness: _____ Date: _____