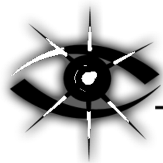

Gregory Kent, M.D.
Drew Dayton, O. D.
Dorian Rammell, O.D

MEDICAL RELEASE AUTHORIZATION FORM

The Health Insurance Portability and Accountability act of 1996 (HIPAA) took effect on April 14, 2003. In order to comply with this regulation, we need authorization to release any health care information.

Name: ____________________________________ Date of Birth: ____/____/____

Release of Information

☐ I authorize the following persons to have access to my healthcare information:

First & Last name:________________________________

First & Last name:________________________________

First & Last name:________________________________

☐ Information is not to be release to anyone other than myself.

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

______________________________ ________________________ ___________

Signature of Patient or Responsible Party *Print Name* *Date*