Dr. Bray and Dr. Young

Medical Information Contact Form (HIPPA)

Patient Name: ____

Date of Birth: ____

Release of information:

◯ I authorize and agree to allow information to be released to the following:

(Please check and give name in detail)

◯ Parent _________________________

◯ Spouse _________________________

◯ Child (ren) _______________________

◯ Other ___________________________

I authorize the release of information including:

1. Diagnosis/ Treatment / Clinical records
2. Insurance Claims/Insurance information/ Financial information
3. Scheduling/ Appointment history

◯ **Information is not to be released to anyone**

This contact information will remain in effect until terminated by patient/guardian in writing. I acknowledge that I have read and completed this HIPPA form that has been given to me by an office representative.

Patient Signature / Guardian ____ Date: ___________

Witness: ____ Date: __________________________