Medical Information Release Form
HIPPA 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:

[ ]: Chris Nichols, MD Pearl Plastic Surgery
145 Lilly Road NE, Suite 101 Olympia, WA 98506
P: 360-878-9300 F: 360-878-9666

[ ] 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.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: ______________
If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ______________________________

The best time to reach me is: (day) __________ between(time) ______________

Patient/Guardian signature: ______________________________ Date: __________

Witness: ______________________________ Date: __________