CAMP LOWELL CARDIOLOGY

HIPAA Release Form

Patient Name: _____ **Date of Birth**_____

HIPAA regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant other)

Please print name, relationship and phone number for each person to whom you are authorizing release of your private health care information and account balances.

_____	_____	_____
Name	**Relation**	**Phone #**
_____	_____	_____
Name	**Relation**	**Phone #**
_____	_____	_____
Name	**Relation**	**Phone #**

This authorization will expire on: _____ One year after being signed.

Patient Signature: _____ **Date**: _____