



Medical Information Release Form Hipaa Release Form

**Stellar Health Care**

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INFO@STELLARHEALTHCAREFARGO.COM

<b>Name:</b> _____
<b>Address:</b> _____
<b>Phone:</b> _____
<b>DOB:</b> _____

**Release of Information**

I hereby authorize the release of my protected health information in accordance with and in the manner described hereafter.  
RELEASE INFORMATION TO: RELEASE INFORMATION FROM:

<b>Name:</b> _____
<b>Address:</b> _____
<b>FAX:</b> _____
<b>Phone:</b> _____

<b>Name:</b> _____
<b>Address:</b> _____
<b>FAX:</b> _____
<b>Phone:</b> _____

**Purpose of Release:**

**Information to be Released:**

<input type="checkbox"/>	CONTINUING MEDICAL CARE	<input type="checkbox"/>	DIAGNOSIS
<input type="checkbox"/>	WORK COMP	<input type="checkbox"/>	EXAMINATION RECORDS
<input type="checkbox"/>	DISABILITY DETERMINATION	<input type="checkbox"/>	LAB REPORT
<input type="checkbox"/>	INSURANCE CLAIM	<input type="checkbox"/>	CLINIC NOTES
<input type="checkbox"/>	LEGAL	<input type="checkbox"/>	HISTORY & PHYSICAL
<input type="checkbox"/>	APPLICATION FOR INSURANCE	<input type="checkbox"/>	FORMAL MEDICAL RECORD
<input type="checkbox"/>	PERSONAL	<input type="checkbox"/>	BILLING / CLAIM INFORMATION
<input type="checkbox"/>	OTHER:	<input type="checkbox"/>	OTHER:

**Method of Delivery:**

<input type="checkbox"/> Pick up in person	<input type="checkbox"/> Mail	<input type="checkbox"/> Fax
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**DURATION OF RELEASE:**

<input type="checkbox"/> No Expiration Date	<input type="checkbox"/> One Year	<input type="checkbox"/> On following date: / /
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I understand this **Release of Information** will remain in effect for the duration specified above unless earlier terminated by me in a writing delivered to Stellar Healthcare. I understand that in the event that my information has already been disclosed by the time my release is revoked, it may be too late to cancel such disclosure. I understand that the failure to sign this authorization or the subsequent termination of this release will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship of Person Signing (If not patient): \_\_\_\_\_