HIPAA Release Form

Patient: Use this form to tell us who is involved in your care so that we may provide them with the information they need to assist you. This form is optional; it is not required. This form does not expire. We will act upon the information you provide on this form unless you inform us that it has changed. This does not apply in the hospital setting.

The individuals I list below are involved in my ongoing care, ReNew staff and physicians may provide them with limited information about my condition and care as needed to assist me. I understand that information specific to drug and alcohol treatment, psychiatric treatment, and AIDS/HIV may be included.

The individuals listed below are involved in my care:

1. _____ _____ _____

Name Relationship Phone #

_____

Address: Street City State

☐ May leave a message with another member of the household

☐ May leave a message on an answering machine or voicemail

2. _____ _____ _____

Name Relationship Phone #

_____

Address: Street City State

☐ May leave a message with another member of the household

☐ May leave a message on an answering machine or voicemail

3. _____ _____ _____

Name Relationship Phone #

_____

Address: Street City State

☐ May leave a message with another member of the household

☐ May leave a message on an answering machine or voicemail

I have carefully read and understand the above, and do voluntarily authorize the disclosure of the above information.

Signature: _____ Date: _____