HIPAA/Medical Release Form

Name: _____ DOB: _____ Date: _____

Federal laws state we cannot give out personal healthcare information unless you give us authorization to do so. By signing this, I hereby authorize TIV Hydration & Wellness to disclose my medical records/treatment to my spouse, children, emergency contacts, primary physician, and or emergency medical services. I also authorize TIV Hydration & Wellness to discuss and share my medical records/treatment and all other information for the purposes of monitoring, quality control, and safety concerns.

The Release of Information will remain in effect until terminated by me in writing

For messages, I give TIV Hydration & Wellness permission to call and leave messages on my phone numbers listed on my intake form as well and email me if an email is listed.

_____

Patient Signature/Date

_____

Witness Signature/Date