Haller & Hug P.C.

HIPPA Medical Records Release Form

Patient Name: _____

Date of Birth: _____

Today's Date: _____

I _____, give permission to Haller & Hug P.C. to release my medical
Name of Patient
information, including test results, past medical history, appointment dates, etc. to

_____, who is my _____.
Name of individual to receive information Relationship to patient

_____
Signature of Patient

Please Note: Medical Information can only be released to immediate relatives, such as spouses and parents of minor children.