

Warhawk Health Services
Medical Information Release Form (HIPAA Release Form)

Name: Doug Niel Date of Birth 09/30/1974

Release of Information

☒ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name: Krystal Niel Phone: (251) 209-4214 Relationship: Spouse

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ Information is not to be released to anyone.

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

Messages

Please call ☐ my home ☐ my work ☐ my cell number: (____)-____-____

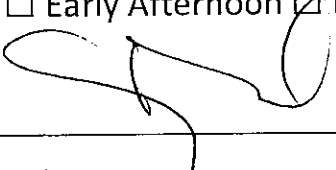
If unable to reach me:

- ☐ Please send me an email ☐ Please leave me a message to return your call
☐ Please leave me a detailed message ☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Early Afternoon ☒ Late Afternoon ☐ Anytime

Signature: 

Date: 10/14/22