SWERDLIN & COMPANY

ACTUARIES AND EMPLOYEE BENEFITS CONSULTANTS

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/___/____

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:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

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

Signed: _____ Date: ___/___/____

Witness:_____ Date: __/___/_____