

# HIPPA Release of Information

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**Note: Your emergency contact has to be listed on this form. If you want them to only have access in case of an emergency, please make sure you specify that.**

I, \_\_\_\_\_,  
hereby grant Lemire Clinic permission to speak with,  
or release any information pertaining to my condition(s) to

\_\_\_\_\_.

**By signing this agreement I understand that I am granting the above named individual direct access to everything in my medical files. This agreement becomes effective today and will remain in effect until further notice is given. With written notification this agreement may be voided at any time.**

**Additional person(s)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

**Do you give us permission to leave messages on your answering machine?**

**Please initial next to one: Yes \_\_\_\_\_**

**No \_\_\_\_\_**