Elite Care Wellness
Vicken Poochikian, MD

Medical Information Release Form (HIPAA Form)

Name: _____ Date of Birth _____

Release Information

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

( ) Spouse _____

( ) Children _____

( ) Other _____

( ) Information is not to be released to anyone.

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

Means of Communication

How do you prefer to be contacted?

- By phone ( ) home ( ) work ( ) cell number _____

- By E-mail _____

Patient Name: _____ Date :_____

Signature:_____

Legal Representative Name:_____Date:_____

Signature:_____