Annette C. LaCasse, D.O., P.C. ❖ 8906 Commerce Rd., Suite #5 ❖ Commerce Twp., MI 48382

HIPAA Medical Information Release Form

Name (Print)_________________________________ **Date of Birth** ____/____/______

Release of Information

I authorize the release of information including diagnosis, examination records, reports, and claims information to:

- ☐ Primary Care Physician ____
  Address ____
  Phone (_____)-_____-_______
- ☐ Spouse ____
- ☐ Child ____
- ☐ Other ____

Messages

I authorize the office of Dr. Annette LaCasse to send appointment reminders to me my on my provided cell phone number, or email.

I UNDERSTAND THAT THE OFFICE OF DR. LACASSE MAY BILL THE INSURANCE COMPANY FOR ANY PROCEDURES/SURGERIES RENDERED. I AUTHORIZE THE RELEASE OF ANY M EDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS. I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES.

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

Signed: ____ Date ____/____/________

Witness: _______________________________________ Date ____/____/________