# Release of Patient Records

**For Fort Wayne Medical Institute (FWMI) to release any information about your or your childs medical records to any person, we must have on file that persons name, their relationship to you, their date of birth along with your signature.**

**This is accordance with federal HIPAA regulations concerning your privacy.**

**We are unable to release information without this signed authorization.**

I _____ hereby authorize FWMI to release my medical information to the people listed on this form. I may revoke or modify this list at any time but it must be done in writing.

Patient Signature: _____ Date: _____

Persons I would allow information about my medical records:

| NAME: | Relationship | Date of Birth |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |