



Medical Information Release Form

(HIPAA Release Form)

Name: _____

Date of Birth: _____

Release of Information

I, [_____], authorize the release of information including my diagnosis and medical records to:
The Fight Like Emilie Foundation.

or

[] My information is not to be released to anyone.

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

Signed: _____ Date: _____

Guardian (if child is under 18) : _____ Date: _____

Print Guardian Name: _____