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**Medical information Release Form**  
*(HIPAA Release Form)*

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

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

- Spouse \_\_\_\_\_
- Child(ren) \_\_\_\_\_
- Other \_\_\_\_\_
- Information is not to be released to anyone.

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

**Messages**

Please call  my home  my work  my cell Number: \_\_\_\_\_

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_