Release Of Medical Information

NAME *(Please print)*: _____ DOB: _____

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

AdvancedHEALTH may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____ DATE _____

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

We charge a $20 flat rate for 1-5 pages plus .50 per additional page and postage.

I understand that AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.

AdvancedHEALTH