Authorization to Release Medical Information

Patient Name: _____

Address: _____

Phone Number: _____ Email: _____

Birthdate: _____ Social Security Number: _____

Other Aliases: _____

Name of Guardian or Legal Representative: _____

Address: _____

Phone Number: _____ Email: _____

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription clearinghouse, consumer reporting agency, employer, or family member to release (Check One) __ all health information about me __ my medical records as described on the following page:

Person / Organization to Release Information: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Fax Number: _____

Patient Signature: _____

Stinson Family Practice

Patient Information:

Patient's Name: (first)_____ (middle)_____ (last)_____
Address: _____
_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birthdate: __/__/____ Sex: _____ Marital Status: _____
Emergency Contact: _____ Phone: _____

Email Address: _____

Insurance Information:

Primary Insurance: _____ / (member ID) _____ / (group number) _____ / (guarantor) _____ / (effective date) _____

Secondary Insurance: _____ / (member ID) _____ / (group number) _____ / (guarantor) _____ / (effective date) _____

By my signature, I am verifying the accuracy of my information and have made any changes where needed.

I authorize any holder of medical or other information about me to release to my insurance company or to the social security administration and health care financing administration or its intermediaries or carrier any information needed for this or a related insurance claim. I permit a copy of this administration to be used in place of the original, and request of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____ Date: _____

STINSON
FAMILY PRACTICE

Consent to Disclose Protected Health Information

Date: _____ Time: _____

I, _____, am granting permission to Stinson Family Practice to allow the following people to have access to my accounting information. I understand that I may revoke this consent by completing a new consent form.

Signature of Patient: _____

Spouse:	
Parent:	
Child:	
Grandparent:	
Grandchild:	
Aunt/Uncle:	
Legal Guardian:	
Other:	