Release Of Medical Information

NAME: _____ 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 _____

AdvancedHEALTH may leave appointment information on my voicemail:

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

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

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

Please note that you will be charged a $20 flat rate for 1-5 pages plus .50 per additional page and postage to cover the cost of the production of your medical records. I understand that AdvancedHEALTH will ask for the identification of the person picking up the patient medical information or products.

Please list all other providers who provide care to you along with their specialty:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent Signature *(if required)*: _____ Date: _____

AdvancedHEALTH