Print Form

Personal Choice HealthCare, PC

Release of Information

Patient Name: _____ Date of Birth:_____

Social Security Number: _____

Permission is needed from you, the patient, before any information can be released to anyone other than yourself regarding your medical care or your relationship with Personal Choice HealthCare, PC. If you desire a spouse, other family member, or friend to be able to obtain test results, billing or payment information, or any other information regarding you, please list their name and relationship below. You may rescind this permission by submitting in writing a desire to do so.

I am aware that reports needed by other health care facilities for my care may be released at the doctor's discretion. Further I understand that reports related to my medical care may be required by my health insurer and I give my permission to release to my health insurer such reports that are required to process any and all claims.

Name	Relationship	Date Given	Initial

Please Initial each entry.

_____ I do not want my information given to anyone other than myself except as is specified above regarding my health care and well being or to satisfy requirements of my health insure. (Please initial)

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date