

PRODIGAL PRIMARY CARE

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE (PRACTICE NAME) TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CHILDREN	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
IN-LAWS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> 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.

(PRACTICE NAME) MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WORK	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC....

RELATIONSHIP			
SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT (PRACTICE NAME) WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.