Post Falls Family Medicine, PA

Release of Information

I (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patients' medical records to any entity, which is, or may be liable for all or part of the provider charges.

I (we) authorize the release and disclosure or any and all medical records to any other entity including by not limited to referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing for the treatment of patient.

I (we) authorize the release of records necessary as assist in reimbursement of benefits to which I (we) may be entitled. I (we) authorized this office and/or its employees to release via fax machine medical records which are needed in order to provide patient with the most appropriate medical care.

I (we) authorize the release of my x-rays, labs and medical results to be left on my answering machine if I am unavailable. Yes____ No_____

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

By signing below, I have read and understand Post Falls Family Medicine Release of information policy.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Patient signature or parent/guardian if minor Date