SAMARITAN HEALTH MINISTRIES

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This document provides the authorization for the release of information as indicated below. Information about you cannot be released to others without your consent, except as authorized by law. Do not sign this release unless it is completed and in your best interests.

Patient: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ Email: _____

People approved to receive medical information or who may pick up prescriptions:

Name: _____ Relationship: _____

Phone #: _____

Information to be Released:

[ ] Next appointment date [ ] Laboratory Reports [ ] X-ray Reports [ ] Medication

Name: _____ Relationship: _____

Phone #: _____

Information to be Released:

[ ] Next appointment date [ ] Laboratory Reports [ ] X-ray Reports [ ] Medication

Name: _____ Relationship: _____

Phone #: _____

Information to be Released:

[ ] Next appointment date [ ] Laboratory Reports [ ] X-ray Reports [ ] Medication

Signature of Patient _____ Date: _____

Witness: _____