Assisted Living On-Site Care

Authorization to Release Information

Name: _____

Address: _____

Social Security: _____ / _____ / _____ **Date of Birth:** ____ / ____ / _____

I authorize the release of my medical information from my medical record to:

Name of Doctor, Hospital, Etc.: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

I do hereby consent and authorize you to release copies of my medical records from other practices, hospitals, and/or clinics, which are part of my medical records. *Please note:* This authorization includes consent for the release of alcohol, drug, psychiatric, and physiological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS related syndromes. It also includes information concerning cancer, cancer screening, and cancer screening results. I agree that a copy of this release or any fax or transmission of this release shall be as valid as this original release. Please send all copies of all requested information as soon as possible to the information listed above.

___ Entire record

___ Specific Information: _____

Signature of Patient / Legal Guardian: _____ Date: _____

Printed Name of Legal Guardian (If Applicable): _____

Legal Guardian Phone (If Applicable): _____

BPUC
PO Box 2268
Hickory, NC 28603
(828) 855-1192 (O)
(828) 358-0832 (F)

For additional copies of this form, please visit www.bowenmd.com/Signing-up