Assisted Living On-Site Care

Authorization to Release Information

Name: _____

Address: _____

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

I authorize the release of my medical information to:

Name of Doctor, Hospital, etc.: _____

Address: _____

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

I do hereby consent and authorize the release 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 the original release. Please send all copies of all requested information as soon as possible to the address listed at the bottom of this document.

___ Entire record

___ Specific Information: _____

Signature of Patient / Legal Guardian:_____Date: _____

Printed Name of Legal Guardian (If Applicable): _____

Legal Guardian Phone (If Applicable): _____

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

www.bowenmd.com

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