Elizabeth A McMorran, NP

PATIENT RELEASE OF INFORMATION

TO SPOUSE/FAMILY MEMBER OR CONSENT FOR RELEASE OF INFORMATION AND/OR TEST RESULTS TO SPOUSE/FAMILY MEMBER AND PRIMARY CARE PROVIDER AND OTHER HEALTH CARE PROVIDERS:

I, _____, give my consent and authorization to the staff of Elizabeth A. McMorran NP to relay my medical information to the following persons. This information may include but is not limited to scheduled appointments, results of laboratory testing, and prescribed medications.

Authorized by: ____Patient _____ Legal Guardian _____ Other

Please complete the following:
This could include non custodial parents/guardians, step-parents, school officials, therapists, pediatricians, hospitals or other health care providers whom you would like to be included in your child's care.

Contacts: Phone Number Relationship to Patient

_____

_____

_____

_____

_____

_____

_____

I understand that this authorization will remain in effect until revoked by me in writing.

Signature: _____ Date: _____

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize Elizabeth A McMorran NP to access my medication history without limitation or exclusion as it reasonably advisable to disclose, retrieve, and view medications issued by a provider.

I understand that this authorization will remain in effect until revoked by me in writing.

Signature: _____ Date: _____