Mason Park
Medical Clinic

PERMISSION TO RELEASE INFORMATION

Below we will discuss the approved forms of contact regarding <u>appointments</u>, <u>results</u>, and/or <u>any other information regarding your treatment</u> here at *Mason Park Medical Clinic;* as well as who is deemed an allowed person of communication regarding the above.

Person(s) of Contact			
Name			
Phone Number			
Relationship			

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items.
<u>If all health information is to be released, then check only the first box.</u>

☐ **ALL Health Information**	☐ History/Physical Exam	☐ Medications
☐ Physician's Orders	☐ Patient Allergies	☐ Diagnostic Imaging
☐ Progress Notes	☐ Discharge Summary	☐ Lab Results
☐ Pathology Reports	☐ Billing Information	☐ EKG Reports

_____ _____
Patient Name *Date of Birth*

_____
Signature of Patient

_____
Representative Printed Name

_____
Representative Signature (If Patient a Minor)

_____ _____
Date (MM/DD/YYYY) *Representative Relation*