

PERMISSION TO RELEASE PATIENT INFORMATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, etc., we **will not** give that information out unless his/her/their name(s) is written below and signed by you.

Patient Name: _____ Date of birth: _____

1. I hereby give permission to the Community Health Center of Franklin County to allow the people listed below	
<input type="checkbox"/>	Pick up written prescriptions or medications
<input type="checkbox"/>	Pick up or discuss test results, specialist appointments, or referrals
<input type="checkbox"/>	Pick up or discuss medical test requisitions (example: lab slips)
<input type="checkbox"/>	Verify or change my appointments at the health center
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____

~OR~

2. I do not allow any information about me released to anyone:	<input type="checkbox"/>
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PLEASE SIGN BELOW

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

PLEASE NOTE:

Releases of Medical Records requires a separate signed authorization.