CHCFC
Community Health Center of Franklin County

PERMISSION TO RELEASE PATIENT INFORMATION

We **will not** give information out to anyone unless their name(s) is written below and signed by you. This release of information does not include record requests to/from other doctor's offices, requests by insurance companies or other outside agencies. You must fill out specific releases for these purposes.

Patient Name: _____ Date of Birth: _____

1. I hereby give permission to the Community Health Center of Franklin County release the following to those listed below:

- ☐ Written prescriptions or medications
- ☐ Pick up or discuss test results or test requisitions (i.e. lab slips)
- ☐ Dental x-rays
- ☐ Discuss specialist referrals or appointments
- ☐ Verify or change my appointment at the health center
- ☐ Discuss dental treatment
- ☐ School nurse, Principal, Psychologist (school-related)

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

~ OR ~

2. I do not allow any information about me released to anyone: ☐

PLEASE SIGN BELOW

Patient/Guardian signature: _____ Date: _____