Rosewood
HEALTHCARE
& MEDICAL SPA

Release of Personal Information Consent

At times we may receive requests by our patients and their family members regarding the patient's health status and other health management information. Including, but not limited to : lab results, radiology results, medication refill request status, billing, and appointment information.

To protect your confidentiality, we ask for your permission to release this information to the individuals you specifically list below. If you are unavailable or become incapacitated, which individuals do you approve our release of information to?

Please take the time to fill out this form with the requested information. If an individual you indicated requests information about you or for you, we will ask their full name, date of birth, and phone number, as well as, your full name and date of birth to be sure they are the one you had previously designated. If you do not have all the information with you please take this form home for completion and return it to us at your convenience.

Name(s) of person(s) you authorize us to release your protected health information to:

Name_____ Date of Birth _____Relationship _____

Address:_____ Phone:_____

Name_____ Date of Birth _____Relationship _____

Address:_____ Phone:_____

Name_____ Date of Birth _____Relationship _____

Address:_____ Phone:_____

_____ **I do NOT authorize you to release my protected health information to anyone.**

I_____, give the employees of Rosewood Health Care permission to release medical information (health status, lab and or radiology results, medication refill requests or status, appointment information, and billing status) Regarding my treatment and ongoing health care needs to the person(s) i have listed above.

Patient Name Printed_____ Date:_____

Patient or Guardian Signature_____

Witness Signature:_____ Date_____