Three Rivers
MEDICAL CLINIC

RELEASE OF HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Patient acknowledges and agrees that Three Rivers Medical Clinic may disclose above mentioned Patient's protected health information and patient medical record information to the following individual(s).

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Email _____

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Email _____

May we leave test results on any of the following? Please check the device(s) of your choice:

- ❍ Home Answering Machine
- ❍ Work Voicemail or Answering Machine
- ❍ Cell Phone Voicemail
- ❍ Email or Patient Web Portal

By signing this HIPAA disclaimer, it allows our office to release an/or obtain the Patient's medical information to and/or from insurance, medical doctors and to whom you list above. The Patient agrees that Three Rivers Medical Clinic may disclose information contained in the Patient's medical records.

At all times, the Patient retains the right to revoke this consent. Such revocation must be submitted to the Three Rivers Medical Clinic in writing.

Patient or Authorized Representative Signature _____

Printed Name _____ Date _____

Three Rivers Medical Clinic
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