BOUNTIFUL LIFE

MEDICAL INFORMATION
Release Authorization

Privacy regulations require a signed release to allow us to speak with your selected family members, friends, or collaborate with other medical professionals regarding your treatment and care. Below, please select the type of release you are authorizing, along with the details requested.

Patient Name _____ Date of Birth _____

☐ **RELATIONAL RELEASE** *I authorize the release of my personal health + financial information to the family members and/or friends listed below.*

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____

☐ **COLLABORATIVE RELEASE** *I authorize my provider(s) to collaborate and discuss my medical history, treatment, and care plans with the following professional(s).*

Clinic or Office: _____ Provider: _____

Address: _____ Phone #: _____

Email: _____

Clinic or Office: _____ Provider: _____

Address: _____ Phone #: _____

Email: _____

This authorization will remain in effect unless cancelled in writing. I understand that cancellation will have no effect on information released prior to receiving the cancellation. An electronic signature or electronic record of this document shall be deemed to have the same legal effect as delivery of an original executed copy for all purposes.

Signature: _____ Today's Date: _____

BOUNTIFUL LIFE

MEDICAL RECORDS
Release Authorization

Privacy regulations require a signed release to allow us to speak with your selected family members, friends, or collaborate with other medical professionals regarding your treatment and care. Below, please select the type of release you are authorizing, along with the details requested.

Patient Name _____ Date of Birth _____

☐ **RECORDS RELEASE** *I authorize Bountiful Life to release a copy of my personal medical records*

Information requested:

☐ X-rays ☐ SOAP Notes ☐ Both ☐ Release to Radiologist ☐ Other

Specifics: _____

Via the following method (please select one):

☐ Email to: _____

☐ Pick-up in clinic

☐ Mail to: _____

This option will incur a $13 mailing fee.

I grant permission for Bountiful Life to release my confidential health information by releasing a copy of my requested medical records to the physician/person/facility/entity listed above. An electronic signature or electronic record of this document shall be deemed to have the same legal effect as delivery of an original executed copy for all purposes.

Signature _____ Today's Date _____