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.

Signature: _____ **Today's Date:** _____

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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** _____

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