Casey City Health
Your health is our priority

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AUTHORITY TO RELEASE PERSONAL HEALTH INFORMATION / MEDICAL RECORDS

I ....

ADDRESS: ....

....

DATE OF BIRTH: .... / .... / ....

REQUEST DOCTOR:

DOCTOR: ....

ADDRESS: ....

PHONE: .... FAX: ....

ADDITIONAL FAMILY MEMBERS:

NAME: ❑ Male ❑ Female .... **Date of Birth:** ...... / ...... / ......

NAME: ❑ Male ❑ Female .... **Date of Birth:** ...... / ...... / ......

NAME: ❑ Male ❑ Female .... **Date of Birth:** ...... / ...... / ......

NAME: ❑ Male ❑ Female .... **Date of Birth:** ...... / ...... / ......

TO RELEASE MY/OUR HEALTH INFORMATION/MEDICAL RECORDS TO DOCTOR:

DOCTOR's NAME: .... AT CASEY CITY HEALTH.

POSTED/FAXED BY STAFF: ....

SIGNATURE OF PATIENT: .... **DATE:** ...... / ...... / ......

PLEASE PROVIDE DIGITAL FILE IN XML FORMAT SUITABLE FOR BEST PRACTICE IF POSSIBLE.

Thank you!

QIP/AGPAL
SPECIALIST IN ACCREDITATION, QUALITY AND RISK MANAGEMENT