Shoreline Wellness and Primary Care, LLC

Authorization for Shoreline Wellness and Primary Care, LLC to Release Health Information

WARNING: Your Personal Health Information (PHI) may be re-disclosed by the receiving entity. PHI Must be picked up in person unless it is to be sent directly to a new facility then it may be faxed.

Patient Information:

Full Name_____
Date of Birth_____ **Last four digits of social security number**_____

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

To Have Your Information to be sent to a Receiving Facility please complete the following information.

Facility/ Provider Name: _____
Address:_____
_____
Phone Number:_____
Fax Number:_____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical records may contain reports, test results, and notes that only a Provider can interpret. I understand and have been advised that I should contact my provider regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any staff member liable for any misinterpretation of the information in my medical record as result of not consulting my provider for the correct interpretation

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

TO BE COMPLETED BY SHORELINE WELLNESS AND PRIMARY CARE, LLC ONLY

Date Request Completed _____ # pages Copied _____

Released by _____
Method _____Picked Up _____Faxed to a Receiving Facility
Facility Sent to _____
Fax Number: _____