AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PROHIBITION OF REDISCLOSURE

This information is being disclosed upon the written consent of the person to whom it pertains. This information may not be released to any other parties.

DATE: _____

Tri-Life Health, PC is hereby authorized to furnish copies of the indicated sections of the health/medical records on:

_____ _____ _____

(Name of patient) (Birth date) (Sex)

The scope and content of the information to be released is as follows:

_____

This information may be released to:

_____

(Name and address of person or organization to which disclosure is to be made)

Tri-Life Health, PC, Dr. Roger Billica, Dr. William Billica and Cindy Adams are hereby released from legal responsibility for the disclosure of records and/or information authorized herein.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this content expires ninety (90) days from when it is signed unless another date is specified below.

Specification of the date, event, or condition upon which consent expires:

_____

_____

_____

Signatures:

_____ _____

(Patient) (Date)

_____ _____

_____ _____

(Parent, Guardian, or Authorized Representative) (Date)

Tri-Life Health, PC
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