AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This form allows me to communicate with your healthcare provider or other persons you have approved

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Parent Name (if minor) _____

I request and authorize Julianne Hagan

to release, obtain or exchange treatment and healthcare information of the patient named above with /to my third-party payers and the following health care providers or other persons:

1 Name: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

2 Name: _____

Addres: _____

Email: _____ Phone: _____ Fax: _____

3 Name: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

4 Name: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

5 Name: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

☐ Yes ☐ No I authorize the release of my lab results and medical records to the person(s) listed above and to submit claims to my health insurance company.

Name _____Date_____

If a minor, Parent Signature:_____