COMMUNITY HEALTH

PATIENT INFORMATION RELEASE

USE ONE RELEASE PER PERSON/FACILITY

I,_____, give permission to all staff at CAN Community Health to speak with _____

(Relationship and Contact Number – Please Print)

regarding all aspects of my care, including, but not limited to, making and canceling appointments, billing and insurance matters, housing, and all issues relating to my medical and dental care.

All information hereby authorized by me to be obtained by CAN Community Health will be held strictly confidential and cannot be released by the recipient without my written consent.
I understand that this authorization will remain in effect until revoked by me in writing.

Date	Client *(E-Signature)*
Date	Client *(Print Name)*
Date	Representative/Guardian *(E-Signature)*
Date	Representative/Guardian *(Print Name & Relationship)*
Date	Witness *(E-Signature & Print Name)*

Withdrawal of Consent

Date consent revoked	Client/Representative/Guardian *(E-Signature)*
Date	Witness *(E-Signature & Print Name)*

Name_____
ID# _____
Date of Birth_____/_____/_____