RELEASE OF CONFIDENTIAL INFORMATION FORM

Patient confidentiality is a priority at Prestige Medical Group. Therefore, it is important that you provide us with the following information to ensure your privacy.

In the event that I, _____(print your name here), am unable to be reached, Prestige Medical Group has my permission to leave any test results or lab results in the following manner(s) – Please check all that apply.

- Spouse_____
- Children – Name(s)_____
- May Call or leave message on voicemail at/on: Home phone:_____

  Cell phone:_____ Work phone:_____
- Other option/person – Name(s) _____

Please list any family members (including spouse), or friends you authorize to receive information on your medical condition(e.g. test results, hospital status, appointment information, etc.) or billing information.

_____

Complete the information below to authorize release of information

PATIENT NAME:_____

- I, _____, **DO NOT** give Prestige Medical Group permission to release medical/billing information.
  (Print Full Name of Person Signing)
- I, _____,give Prestige Medical Group permission to release medical/billing information to the following person(s):
  (Print Full Name of Person Signing)

  Name _____ Relationship _____Phone_____

  Name _____ Relationship _____Phone_____

  Name _____ Relationship _____Phone_____

By signing below, I understand that I have read and understand the privacy practices for Prestige Medical Group. I also understand that I may obtain a copy either by request or by visiting PrestigeMedicalGroup.org.

Signature_____ Date_____