promise healthcare

Promise Healthcare, dedicated to improving the health of the community through treatment, prevention, and education.

WHO CAN HAVE YOUR HEALTH INFORMATION?

Please fill out this form. It will tell us which family members and friends have your permission to haveyour health information.

Patient Name:	Date of Birth:

ABOUT THIS FORM:

- Letthose listed below have information about your medical care of payment
- Informs those listed below or a disaster relief organization of your location, health or death

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:

1. Name:	Relationship to you:	
Phone #:	Street Address:	
City:	State:	Zip Code:
2. Name:	Relationship to you:	
Phone #:	Street Address:	
City:	State:	Zip Code:
3. Name:	Relationship to you:	
Phone #:	Street Address:	
City:	State:	Zip Code:

PLEASE SIGN HERE:

By signing below, I allow Promise Healthcare to talk about or release my health information with the people listed above.

Mark All You Approve:

☐ **All Information**

☐ **Billing Information** ☐ **Appointment Information** ☐ **Lab results** ☐ **Testing Results**

☐ **Treatment(s)** ☐ **Dental Services**

☐ **Other:** _____

***Please note: We will not discuss mental health, developmental disabilities, alcohol/drug abuse, genetics, or HIV/AIDS/STDs with an additional sign release form.*

Patient/Parent/Guardian Signature:	Today's Date:

Your permission expires in one year unless cancelled in writing.

Revised – Effective 04/14/2021