Balanced Wellness Primary Care

Kristin Mahan APRN Danielle Mallory APRN Kathleen Eagle APRN Tracy Jullarine APRN Joseph O'Keefe MD

PERMISSION TO SHARE HEALTH INFORMATION

Patient Name_____ Date of Birth_____

By signing below, I give permission to the person(s) listed to receive information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared to assist with my continuing care. Any information requested that does not pertain to assisting with my healthcare and any requests for copies of medical records will require a HIPAA compliant authorization. **This permission will be considered ongoing until I state in writing otherwise.**

Date of Permission	Name of Individual/Relationship to Patient	Comments/Instructions (i.e. pick up meds, disclose test results, etc.)

The Provider/staff has my permission to: (please check all that apply)

☐ Leave a detailed message at home with my spouse or (Name/Relationship)_____

☐ Leave a detailed message on my cell phone: cell #_____

☐ Leave a detailed message on answering machine: #_____

☐ I do NOT authorize Balanced Wellness Primary Care, LLC to release my information to anyone.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Printed Name of Patient/Legal Guardian Relationship (if Guardian)