MERCY WELLNESS CLINIC
FAMILY PRACTICE

Medical & or Billing Record Disclosure

(Who is allowed to access your medical records: Spouse, Family Member, Partner, Parent, Etc)

I, _____, *(your name)* give authorization for my healthcare information to be released to the following individual(s):

1. Persons Name:_____Relationship:_____
Phone #::_____ Email: _____

☐ Medical Records ☐ Billing Records ☐ All Records

2. Persons Name:_____Relationship:_____
Phone #::_____ Email: _____

☐ Medical Records ☐ Billing Records ☐ All Records

3. Persons Name:_____Relationship:_____
Phone #::_____ Email: _____

☐ Medical Records ☐ Billing Records ☐ All Records

4. Persons Name:_____Relationship:_____
Phone #::_____ Email: _____

☐ Medical Records ☐ Billing Records ☐ All Records

5. Persons Name:_____Relationship:_____
Phone #::_____ Email: _____

☐ Medical Records ☐ Billing Records ☐ All Records

Patient Signature:_____
Date:_____

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