Elite Family Health
916 East Main Street, Suite 100
Greenwood, IN 46143
317-889-0900
Fax: (317) 889-0922
elitefamilyhealth.com

Authorization to Disclose Information

I, _____ give my consent for Elite Family
(Name of Patient)
Health to release my medical and billing information to the person(s) named below.

I, _____ being the parent or legal guardian of
(Name of Parent or Legal Guardian)

_____, give my consent for Elite Family
(Name of Patient)
to release the medical and billing information of this child to the person(s) named below.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

May we leave a message on your home number voice mail or answering machine? _____yes_____no

Telephone Number: (_____)_____

May we leave a message on cellular telephone? _____yes_____no

Cellular Number: (_____)_____

I also understand that it is my responsibility to notify Elite Family Health of any changes in authorization. This authorization is valid indefinitely unless we receive written notification of changes. If this authorization is for a minor child, I understand that this authorization is valid indefinitely unless we receive written notification of changes; the above named child becomes emancipated, or the above named child reaches eighteen (18) years of age.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____
Printed Name of Patient, Parent or Legal Guardian

_____
Signature of Witness from Elite Family Health